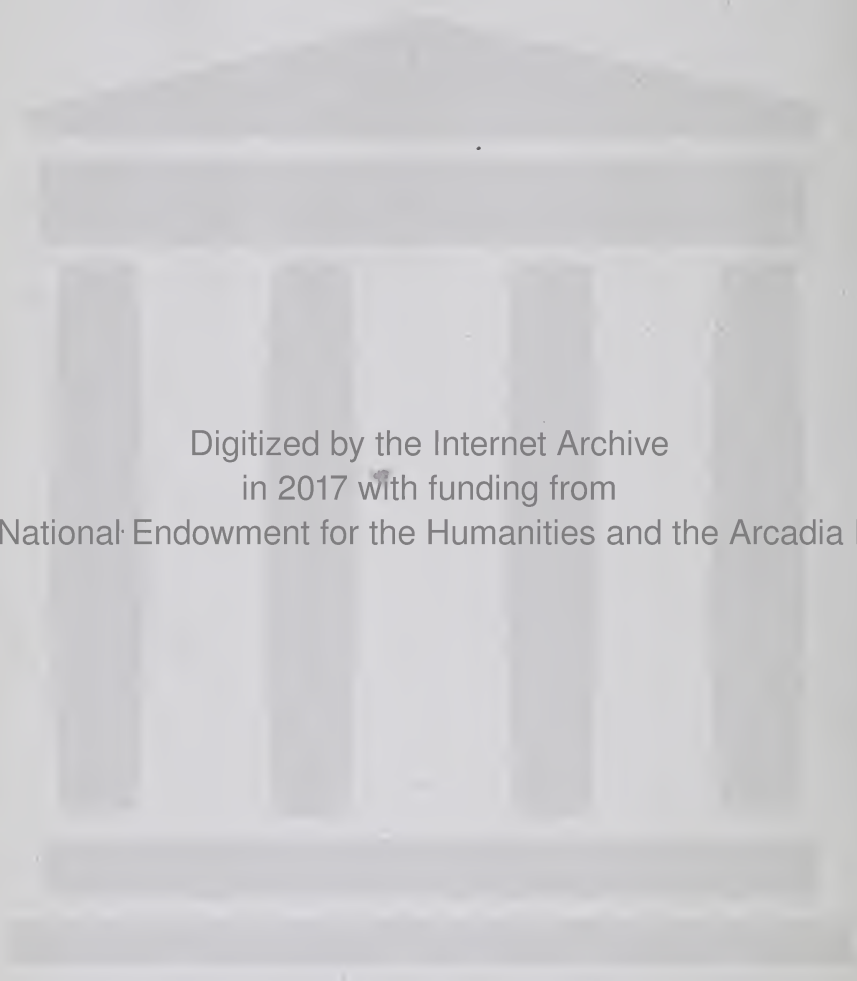


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TRANSACTIONS TWENTY-SIXTH ANNUAL SESSION

# THE JOURNAL

OF THE

NEW MEXICO MEDICAL SOCIETY

Published Quarterly Under Direction of the Council

DR. G. S. McLandress, Editor-In-Chief, Albuquerque.

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ALBUQUERQUE, N. M., JUNE 15, 1907

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## CONTENTS

Our President.....	4
Minutes of House of Delegates.....	6
Minutes of the General Session.....	10
Report of the Secretary.....	12
Roll of Membership.....	17
Relation of Christian Science to the Practice of Medicine, Dr. S. A. Mil- likan .....	19
The Wise General Practitioner as a Factor in the Prevention of Tubercu- losis, Dr. C. W. Taylor-Goodman.....	20
Book Reviews.....	24

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Dr. Robert E. McBride, elected President of the New Mexico Medical Society at its 26th annual meeting is a man who has reason to be proud of his record. But three years ago he located in this Territory and, because of zealous and conscientious work as our Secretary, because of known executive ability and a pleasing personality,

Las Cruces where he enjoys a large and lucrative practice.

Born and reared in Louisiana he is possessed of that charming affability so characteristic of the Southern gentleman; with this gentle inheritance is tempered a profound sense of duty to his profession which he holds inviolate.

Our President is a man of whom we



he has gained for himself the highest office in the gift of this Society.

Dr. McBride was born in Thibodaux, La., in 1873, and after being graduated from the Tulane high school immediately took up the study of his chosen profession and was graduated from the Tulane Medical College in 1896. After some years of hospital work and practice in Louisiana he came to New Mexico and located at

are proud, and at this time when our numbers are so rapidly increasing, it is fortunate that a man so enthusiastic, so forceful and diplomatic, is at the helm.

Though his professional work overshadows everything else, Dr. McBride is identified with several important business interests. He is surgeon for the Santa Fe Ry., and is President of the Board of Regents of the Agricultural College at Mesilla Park.

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OF THE

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Second Vice-Pres., P. M. Steed.....Deming  
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Council: W. R. Tipton.....Las Vegas  
G. W. Harrison.....Albuquerque  
S. D. Swope.....Deming

### Affiliated Societies.

Las Vegas, Bernalillo County, Chaves  
County, Grant County, Dona Ana County,  
Luna County, Otero County.

## MINUTES OF HOUSE OF DELEGATES

New Mexico Medical Association, Las Cruces,  
N. M., May 8th and 9th, 1907.

WEDNESDAY, MAY 8TH, 5 P. M.

The opening of the House of Delegates had been delayed until this hour by the tardiness of the train bearing the president and several members. The president, Dr. T. B. Hart, called the meeting to order at 5 P. M. The secretary was at his desk and the following delegates present:

Bernalillo County Medical Society—  
Dr. G. W. Harrison, Dr. C. W. Taylor-Goodman.

Luna County Medical Society—Dr. S. D. Swope.

Chavez County Medical Society—  
No delegate.

Las Vegas Medical Society—No  
delegate.

Otero County Medical Society—Dr. G. C. Bryan.

Dona Ana County Medical Society—  
No delegate.

Grant County Medical Society—S. A. Milliken.

The credentials of the above named delegates being in due order were approved.

On motion of Dr. S. D. Swope, seconded by Dr. G. W. Harrison, the minutes of the proceedings of the House of Delegates and of the general sessions of the previous year were approved as published in the Journal.

The report of the secretary was read and passed for action later.

The council reported favorably on the application of Drs. J. C. Slack of Clayton, J. Y. Lapsley of Van Houten and F. F. Doepp of Carlsbad and on motion duly seconded they were elected to membership, the first named, Dr. J. C. Slack under the old ruling regarding members from the old Territorial Society and the others as new members.

The report of the secretary was next taken up and the various matters contained therein were disposed of as follows:

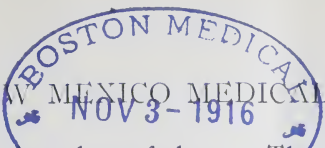
Exhibit "A", dealing with a protest from the Grant County Medical Society was passed for the time being.

Exhibit "C", dealing with a matter regarding the membership of several physicians at Fort Stanton was referred to a committee composed of Drs. C. W. Taylor-Goodman and S. D. Swope with instructions to examine the matter contained therein and to report next morning recommending some course of action.

The resolution embodied in exhibit "E" was endorsed. This resolution is as follows:

"*Whercas*, The value of perfect sight and hearing is not fully appre-





ciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures, therefore, be it

*Resolved*, That it is the sense of the New Mexico Medical Association that measures be taken by boards of health, boards of education and school authorities, and, where possible, legislation be secured looking to the examination of the eyes and ears of all school children, that disease in its incipency be discovered and corrected."

The matter contained in a letter read at this time dealing with the paying of the expenses of a delegate to the National Legislative Committee was, after some discussion, tabled indefinitely.

In the matter of the delinquents to the San Francisco Fund, the secretary was instructed to notify the delinquents that they were in arrears and that the House of Delegates would expect them to pay up promptly in order to retain good standing.

The matter of insurance fees was next considered and on motion of Dr. S. D. Swope, seconded by Dr. G. W. Harrison it was resolved that the House of Delegates recommend to the general meeting that they endorse the statement and resolution that the members of this association deem it unwise, improper and unprofessional to accept less than five dollars (\$5) for any life insurance examinations from any of the old line companies. This not to apply to fraternal insurance organizations.

The following resolution was offered by Dr. S. D. Swope and being duly seconded by Dr. G. W. Harrison was passed until morning for action:

*Resolved*; that this body shall in the future be known as and work under the old name of the *New Mexico Medical Society*.

The following amendment to section 42 of chapter 5 of the By-Laws was offered by Dr. G. W. Harrison and was passed to the table to be acted upon at to-morrow's session: After the words "General Session" add: "Only those in attendance at the annual session at which the election occurs shall be eligible for election."

At this time Dr. G. W. Harrison seconded by Dr. S. D. Swope, moved that due credit be given Dr. E. J. Pring for his work in securing the passage of the bill requiring the registration of births and deaths. The motion being put to the House was unanimously carried, whereupon the House adjourned until to-morrow (May 9th) at 8 o'clock.

THURSDAY MORNING, MAY 9TH, 1907.

The House was called to order by Dr. Hart at the hour named, with the same delegates present as at yesterday afternoon's session. The minutes of yesterday's session were read and approved.

The report of the special committee appointed to deal with the matter contained in exhibit "C" was read and on motion duly seconded was approved and the secretary instructed to act accordingly. The report is as follows: "To the House of Delegates:—

We your committee appointed to investigate the matter of the admission of Drs. Markoe, Green, Carrington, McKirley and Roberts, recommend that they be admitted to full membership in this Association without question.

We further recommend that the statement of Dr. Bryan together with such other documentary evidence as he may see fit to offer be accepted as prima facie evidence of his having paid the membership fees herein in contro-

versy to the proper officer of the New Mexico Medical Association.

S. D. SWOPE,  
C. W. TAYLOR-GOODMAN,  
Committee."

The report of the treasurer was next presented and having been read was on motion duly seconded, referred to the Council for auditing.

The resolution changing the name of the "Association" to that of the "*New Mexico Medical Society*" offered yesterday was called up and on motion of Dr. G. W. Harrison, seconded by Dr. G. C. Bryan was carried. It was explained that this change in name was deemed advisable owing to some of the Territorial laws.

The amendment to section 2 of Chapter 5 of the By-Laws offered yesterday was next called up and on motion of Dr. S. A. Milliken, seconded by Dr. G. C. Bryan was duly carried. (It was explained that this change was made necessary in order to be in line with similar requirements in the By-Laws of the American Medical Association.)

The matter contained in exhibit "A" was after some discussion, tabled indefinitely.

At this time Dr. T. C. Sexton presented his credentials as a delegate from the Dona Ana County Medical Society and was admitted to membership in the House.

It was moved by Dr. Bryan that when this meeting finally adjourns that it adjourn to meet in Albuquerque in the fall of 1908 and that hereafter the regular annual meetings of the society be held in the fall of each year. This motion was duly seconded and on being put to a vote of the House carried unanimously.

It was moved by Dr. Bryan and seconded by Dr. Harrison that the Coun-

cil be requested to call the meeting for 1908 as near to the time of the Territorial Fair as possible. This motion prevailed. The bills presented to the House for payment were passed to the Council for auditing.

Election of officers being declared in order the House proceeded to name the officers for the ensuing year with the result that the following were elected to serve until the next meeting:

President—Dr. R. E. McBride, Las Cruces.

Vice-President (first)—G. K. Angle, Silver City.

Vice-President (second)—P. M. Steed, Deming.

Vice-President (third)— . . . . .

Secretary—G. S. McLandress, Albuquerque.

Treasurer—C. G. Duncan, Socorro.

Delegate to American Medical Association—W. R. Tipton, Las Vegas.

Alternate delegate to A. M. A.—T. B. Hart, Raton.

(The delegate and Alternate to A. M. A. were elected for 2 years.)

Councillor to succeed Dr. G. W. Harrison (elected for 3 years)—G. W. Harrison (re-elected).

Councillors holding over W. R. Tipton (term expires 1908)—S. D. Swope (term expires 1909).

Committee on Scientific Work:—

Dr. E. S. Bullock, Silver City, Chairman; Dr. G. S. McLandress, Albuquerque, (Secretary); Dr. E. B. Shaw, Las Vegas.

Committee on Public Policy and Legislation:

Dr. G. W. Harrison, Albuquerque, Chairman; Dr. C. G. Duncan, Socorro; Dr. H. M. Smith, Las Vegas; The President—ex-officio; The Secretary—ex-officio.

The election having been completed the matter of preparing a list of names

for presentation to the Governor from which he is to select the members of the Board of Health in accordance with the provisions of the act of the recent Legislative Assembly was under discussion when the time for the general meeting was announced, whereupon the House adjourned until one o'clock this afternoon.

THURSDAY AFTERNOON, MAY 9TH.

The House was called to order by the President at the hour named with all of the members present who had been present when the House adjourned in the morning.

The question of the list of names being under consideration, it was moved, seconded and carried that the list be restricted to fifteen names.

Here the house resolved itself into a committee of the whole to select a list of names and after due consideration agreed to report to the general meeting that the following names be presented as the official list of the New Mexico Medical Society to the Governor of the Territory:

1. W. S. Harroun, Santa Fe.
2. G. W. Harrison, Albuquerque.
3. P. G. Cornish, Albuquerque.
4. J. J. Shuler, Raton.
5. E. S. Bullock, Silver City.
6. W. T. Joyner, Roswell.
7. C. M. Whicher, Carlsbad.
8. J. R. Gilbert, Alamogordo.
9. E. B. Shaw, Las Vegas.
10. W. R. Tipton, Las Vegas.
11. J. M. Cunningham, Las Vegas.
12. S. D. Swope, Deming.
13. B. E. Lane, Las Cruces.
14. C. W. Gerber, Las Cruces.
15. C. G. Duncan, Socorro.

The Committee of the Whole here arose and the House re-convened and the above named list was presented to the House where, upon motion duly seconded and carried the above list

was adopted and the secretary was instructed to certify to the list and together with the President and Dr. G. C. Bryan of Alamogordo was instructed to present same to the in-coming Governor, provided the general session of the Society should approve same. This motion was made by Dr. S. D. Swope of Deming and seconded by Dr. C. W. Taylor-Goodman of Albuquerque.

At this time Dr. G. W. Harrison of Albuquerque called up the amendment to Article ten (X) of the Constitution offered at the 1906 meeting at Albuquerque and which under the rules had been on the table for one year. The secretary reported that the amendment had been published. On motion of Dr. G. W. Harrison, seconded by Dr. G. C. Bryan, the amendment was duly carried, after having been made to specify a time. The article as amended now reads as follows:

"That all of Article X be struck out and the following substituted therefor: 'That all applicants for membership, regardless of societies or associations that they may belong to or from which they may bring cards, be elected as any other members and that each county society is hereby authorized to require a certain number of months (not less than six) residence before admitting to membership provided that all other requirements of the Constitution and By-Laws be complied with.'"

Dr. H. D. Nichols of Tucumcari was elected to membership, the Council having recommended him.

The report of the Council on the bills presented for payment and on the reports of the secretary and the treasurer was here read and adopted. The report is as follows:

"To the House of Delegates:

We have examined carefully the re-



ports and records of the secretary and find them correct.

We especially commend the work of the secretary and recommend that a vote of thanks from this society be offered to Dr. McBride for the efficient and enthusiastic service he has rendered to this society.

We further find that the report of the treasurer, in the absence of any books, papers or receipts other than a simple statement is insufficient and so incomplete that we are unable to make a satisfactory report.

We have carefully examined the bills of the chairman of the arrangement committee and expense account of the secretary for the current year amounting to \$221.56 and recommend that they be allowed."

On motion duly seconded and carried an appropriation of Two hundred and twenty one-dollars and fifty-six cents was made to pay the bills mentioned in the above report.

It was moved by Dr. G. W. Harrison, seconded by Dr. T. C. Sexton, that the present editor-in-chief of the Journal together with the board of associate editors be re-elected for the incoming year. This motion being put to a vote was duly carried.

It was moved by Dr. G. C. Bryan, seconded by Dr. S. A. Milliken, that the Council be instructed to look into the matter of compensation of the secretary-editor and the matter of income of the Journal, with power to act as they deem best. This motion, on being put to a vote was duly carried.

The report of the Council on suitable resolution on the death of members during the past year was read and ordered approved, and made a part of the records of the Society.

There being no further business the House of Delegates of the Twenty-

Sixth Annual meeting of the New Mexico Medical Society then adjourned *sine die*.

R. E. McBRIDE,  
Secretary.

*Whereas*; By the wisdom of Divine Providence, our esteemed members, Dr. S. M. Lane, of Silver City, Dr. Joseph Kornitzer of Socorro and Dr. C. A. Keihl of Albuquerque, have been removed from their earthly labors,

*Be it Resolved*, That in the death of our brothers the New Mexico Medical Society has been deprived of honorable associates,

*Be it Further Resolved*, That the sympathy of this Society is hereby extended to the bereaved families and friends, and

*Be it Further Resolved*, That a copy of these resolutions be sent to the respective families and a record made of them on the minute book of this Society.

S. D. SWOPE,  
G. W. HARRISON,  
Councillors.

---

#### MINUTES OF THE GENERAL SESSION

---

Of the New Mexico Medical Association, at  
Las Cruces, N. M., May 8th and 9th, 1907.

---

WEDNESDAY MORNING, MAY 8TH, 1907.

In the absence of the President and all of the vice-presidents the meeting was called to order by the secretary, Dr. R. E. McBride of Las Cruces, who announced that the Council had instructed him to call the meeting to order and to preside during the morning hours and until the arrival of the President, T. B. Hart, who had telegraphed that he would be on the delayed train due to arrive at three o'clock in the afternoon.

The secretary also announced that the Council had decided that inasmuch

as there were a number of members with President Hart on the overdue train that the formal opening of the session would be postponed until three o'clock in the afternoon and that the scientific program as outlined for the afternoon session would be begun at this time and completed at the meeting of the afternoon.

Reverend G. W. Dunlap was asked to invoke Divine Guidance, the members all standing.

After the invocation the first paper was called. This was a paper on "Scarlatinal Sore-Throat," by Dr. T. C. Sexton of Las Cruces. The paper was listened to with much interest and was discussed by Dr. G. W. Harrison, G. K. Angle, P. M. Steed, S. D. Swope, G. C. Bryan, James Vance, W. C. Field and R. E. McBride. The reading of the paper and the discussion had taken up all of the morning hour and the meeting adjourned until three o'clock in the afternoon.

#### WEDNESDAY AFTERNOON, 3 P. M.

The meeting was called to order at three o'clock by the president, Dr. T. B. Hart of Raton. The secretary was at his desk. After prayer by the Rev. G. W. Dunlap, the address of welcome was delivered by Hon. R. L. Young of Las Cruces, president of the Mesilla Valley Chamber of Commerce.

Dr. S. D. Swope responded on behalf of the profession in his usual happy manner.

Dr. T. B. Hart, president, then delivered his annual address, the subject being "Medical Education."

Paper No. 2 was then called and Dr. E. S. Bullock of Silver City, who replaced Dr. Lake, presented a very interesting paper dealing with his methods of treating Laryngeal Tuberculosis. This paper was discussed by Dr. S. D. Swope of Deming and Dr. B. F. Stevens of El Paso, Texas.

Dr. James Vance of El Paso, Texas, read a most interesting and exhaustive paper dealing with the "Surgical Treatment of the Uterus Complicated by Pregnancy." This paper was discussed by Dr. G. C. Bryan and Dr. F. T. B. Fest.

Dr. G. C. Bryan presented a paper on "Interesting Cases of Tumor of the Thyroid." This most interesting paper dealing with the actual cases as Dr. Bryan saw them as well as having a most excellent report on the records of all known similar cases was discussed by Dr. S. D. Swope, Dr. G. W. Harrison, Dr. James Vance and Dr. F. T. B. Fest.

Dr. S. A. Milliken's paper on "The Relation of Christian Science to the Practice of Medicine" was next read and discussed by Dr. C. G. Duncan, E. S. Bullock, James Vance, G. C. Bryan, F. T. B. Fest, and others, after which the general session adjourned until 10 o'clock Thursday morning, May 9th.

#### THURSDAY MORNING, MAY 9TH.

The meeting was called to order by Dr. T. B. Hart, President, who asked Rev. G. W. Dunlap to offer the invocation.

The first paper for the morning was that by Dr. C. W. Taylor-Goodman of Albuquerque on "The Wise General Practitioner as a Factor in the Prevention of Tuberculosis." This paper was discussed by Dr. G. S. McLandress, Dr. B. F. Stevens, Dr. S. A. Milliken and others.

Dr. F. T. B. Fest then read his most excellent paper on "Orthotic and Physiologic Albuminuria and Their Relation to Tuberculosis." This paper was discussed by Dr. S. D. Swope, Dr. G. W. Harrison, Dr. J. L. Burnham, and Dr. H. D. Nichols.

Dr. S. A. Milliken then read his paper on "The Necessity of Exercise in the Treatment of Tuberculosis" the

discussion on which was opened by Dr. C. W. Gerber and continued by Drs. F. T. B. Fest, J. P. Kaster, J. L. Burnham, W. C. Field, R. E. McBride, and closed by Dr. S. A. Milliken.

Dr. Clifford Losey of Las Vegas and Dr. J. R. Gilbert of Alamogordo both being absent and the hour being near noon the meeting adjourned until two o'clock this afternoon.

THURSDAY AFTERNOON, MAY 9TH.

The meeting was called to order at the hour by the president.

Dr. B. F. Stevens of El Paso read his paper on "Primary Tuberculosis of the Caecum and Appendix with report of a case." This paper was discussed by Drs. Sexton, Pickels and Swope.

The "General Discussion on Tuberculosis and the Tubercular Problem" was next called and under this heading the Association spent over an hour in discussing various phases of the tubercular question. This discussion was indulged in by Drs. J. P. Kaster, F. T. B. Fest, S. A. Milliken, S. D. Swope, G. W. Harrison, Hatfield, W. C. Field, and others.

At this time the secretary made a report of the proceedings of the various sessions of the House of Delegates and asked that the following matters be considered by the Association in General Meeting and either approved or disapproved, viz:

(1). Insurance Fees Resolution, (see proceedings House of delegates meetings).

On motion of Dr. F. T. B. Fest, seconded by Dr. P. M. Steed, the House resolution on the insurance fee question was approved by the general meeting.

(2). List of names to be presented to the Governor from which to appoint a Board of Health (under New law) (see proceedings of House meetings for list).

On motion of Dr. G. S. McLandress, seconded by Dr. W. C. Field, the list as recommended by the House of Delegates was made the official list of the Association.

At this time the Council reported through Dr. S. D. Swope that it recommended that the sum of one hundred dollars be tendered the Secretary-Editor as salary for the ensuing year whereupon it was moved by Dr. C. W. Taylor-Goodman and seconded by Dr. C. G. Duncan that the society do approve of the recommendation of the council and that the salary of the secretary-editor be fixed at \$100 for the ensuing year. This motion being put to the meeting was adopted.

The general business of the meeting having been completed the president-elect, Dr. R. E. McBride, was introduced by the retiring president Dr. T. B. Hart and asked to take the chair. Dr. McBride in a few words thanked the Society for the honor conferred and pledged himself to make every effort to do his part through the year.

Dr. G. W. Harrison moved a vote of thanks to the Dona Ana County Medical Society for their entertainment. This motion was seconded by Dr. G. W. Bryan and was unanimously adopted, after which the meeting adjourned *sine die*.

R. E. McBRIDE,  
Secretary.

---

#### REPORT OF THE SECRETARY

---

Of New Mexico Medical Association, 26th  
Annual Session, Las Cruces, N. M.,  
May 8 and 9, 1907.

---

To the President and Members of the  
House of Delegates of the New  
Mexico Medical Association.

Gentlemen:

In compliance with the requirements  
of section four of chapter six of the



By-laws of this Association, the secretary begs leave to submit this, his annual report.

The membership of the Territorial Association now numbers divided as follows:

Las Vegas Medical Society.....	20
Bernalillo County Medical Society	24
Chavez County Medical Society..	12
Otero County Medical Society....	7
Luna County Medical Society....	5
Dona Ana County Medical Society	10
Grant County Medical Society...	10
Members at large not members of a component county society.....	27
Total .....	115

There are seven (7) counties which maintain a county medical society in affiliation with the Territorial organization, namely:

Las Vegas Medical Society.  
Bernalillo County Medical Society.  
Dona Ana County Medical Society.  
Chavez County Medical Society.  
Grant County Medical Society.  
Luna County Medical Society.  
Otero County Medical Society.

No new county societies have been added during the past year although there are one or more counties, notably Santa Fe and Colfax where there seem to be more than a sufficient number of practitioners to maintain an organization. Eddy County likewise should be organized and perhaps one or two others. No steps have been taken so far as the secretary knows looking toward this end and it would seem that the Association ought to direct its efforts towards organization wherever this is practicable.

#### SAN FRANCISCO FUND.

At the Albuquerque meeting the secretary was authorized to raise a mini-

um appropriation of one hundred dollars for the benefit of the San Francisco physicians who had suffered during the earthquake. The instructions were obeyed as far as carrying out the issuing of the call was concerned, but the secretary found himself without any definite authority to enforce the collection of the extra assessment and as a result only 63 dollars was raised by this means, the remainder having to be made up out of the general fund of the Association. The Las Vegas Medical Society, the Chavez County Medical Society, the Luna County Medical Society, and nine individual members have not paid any attention to this call. The general fund has been taxed to pay this amount and it seems that a resolution of some sort is needed looking toward the enforcing of these collections.

#### CARD INDEX.

The card index now contains the records of one hundred and fifty-five physicians of the Territory. There are, according to the best data obtainable about two hundred and sixty-five or seventy physicians practicing in the Territory at this time, therefore the card index is not yet as complete as it should be. It is a matter of no little difficulty to get the desired information and necessitates quite a lot of correspondence, the results of which are not always satisfactory. Replies are not always as readily obtained as one would imagine. It is earnestly desired that this index be completed as soon as is possible and then kept up for it is one of the most valuable assets of the Association and of the profession at large. It has shown that there are a large number of desirable men in the Territory who ought to be made members of this Association and it would appear that the time is ripe for some effort to be made to increase the membership.

## MEDICAL PRACTICE ACT.

The recent session of the legislature passed a new medical practice act which, in its provisions, is a compromise between the extreme ideas and opinions of the members of the profession. This act was passed as a result of the combined efforts of the Board of Health, the Legislative Committee of this Association and some individual physicians who were interested. The act was printed in full in the March issue of the Journal and has doubtless become familiar to each of you.

In this connection the secretary desires to call attention to that portion of section one which says: "The Governor shall appoint the members of said Board as other Territorial Officers are appointed from a list to be furnished him by the New Mexico Medical Society or Association, and shall from a similar list fill any vacancies occurring in said Board, etc.." The members of the present Board of Health were appointed by the Governor without any list having been furnished by this Association so far as your secretary knows and there are on the Board two physicians who are not members of this Association. The first of these is Dr. F. F. Doepp of Carlsbad, whose application for membership will come before you for action at this session and the second is Dr. O. J. Westlake, of Silver City. In regard to Dr. Westlake the secretary desires to call your attention to the following protest and correspondence which are here presented as "Exhibit A."

## MEMBERSHIP IN AMERICAN MEDICAL ASSOCIATION.

Under the provisions of the present Constitution of the American Medical Association it is necessary that a physician be in good standing in the component State or Territorial Association

of the State or Territory to be eligible to membership in the American Medical Association. In attending to the routine work of the office your secretary found that there were a number of men in the Territory who claimed membership in the American Medical Association and yet were not members of the New Mexico Medical Association. As this was plainly a violation of the Constitution of the A. M. A. and one which did no good to the Territorial Association, your secretary took the matter up with the secretary of the American Medical Association, the correspondence of which is here presented to you as exhibit "B". This correspondence resulted in the calling to task of those members who were so holding membership in violation of the law and the dropping from membership in the A. M. A. of two or three members until such time as they will have complied with the requirements.

## MARKOE MATTER.

Among the names dropped from the roll under the above mentioned correspondence and ruling was that of Dr. W. W. Markoe of Fort Stanton, New Mexico. Dr. Markoe claimed membership in the New Mexico Medical Association. This claim of Dr. Markoe brought about a lot of correspondence between Drs. Markoe and Carrington of Fort Stanton and Dr. Bryan of Alamogordo on the one hand, and your secretary on the other, with the result that your secretary finds that there is either some error on the part of some one or that the officer, who was secretary previous to the present incumbent has failed to account for forty dollars (\$40). This correspondence is herewith presented to you as Exhibit "C" and your secretary would request that it be carefully studied and some definite action taken in the matter.

## PURE FOOD LAW.

The Pure Food Bill is now in operation and as Exhibit "D" there is presented to you for your information some correspondence in regard to section 7 of the aforementioned Act. It will be seen from this correspondence that the question at issue has not as yet been definitely settled.

## DISTRICT MEDICAL SOCIETY.

In recording the returns from the permanent record blanks your secretary has noticed some reference to a district medical society composed of the physicians of Roosevelt, Chavez and Eddy counties. This society, if still in existence, should be invited to become a component society of the New Mexico Medical Association. Inasmuch as Chavez County has a county society and as mention has already been made of the number of physicians in Eddy county, your secretary has thought best to have this matter passed on by this body to which this question is now referred for action.

## ORGANIZATION.

Just here seems the time to say that it is evident that the condition of affairs medical in the Territory would permit of a better organization of the profession and it would seem that a determined effort should be made by the Association towards increasing the membership of this Territorial Association. If some definite plan of campaign could be outlined at this meeting results would be sure to follow.

## INSURANCE FEES.

The matter of insurance fees ought to receive some attention at this meeting. A number of insurance companies have requested lists of available men for examiners and in one instance have made a direct request for recommenda-

tion as to the best men in the Territory—that is the most competent men. Your secretary has not refused to give the lists where possible, but he has refused to pass upon the competency of available men. It appears from this that the companies desire only the best men, yet are not always willing to pay a fee commensurate with the work and the responsibility. Quite a number of State Associations have passed upon this question and its mention here is made in order to ascertain what action, if any, this Association desires to take in the matter.

## COUNCIL ON MEDICAL EDUCATION.

The Council on Medical Education of the American Medical Association held a meeting in Chicago in April. To this meeting our Territorial Association was entitled to a delegate and Dr. J. J. Shuler of Raton was appointed by President T. B. Hart to represent this organization at that meeting and his credentials furnished him.

## DELEGATE TO A. M. A.

It is necessary for you at this session to elect a delegate and an alternate delegate to represent this Association in the House of Delegates of the American Medical Association. Membership in good standing in the A. M. A. for at least two years is necessary to eligibility for membership in the House and it is desired that this fact be remembered when naming the delegates.

## EXAMINATION OF EYES AND EARS OF SCHOOL CHILDREN.

As Exhibit "E" is reported a letter received from Dr. Frank Allport of Chicago asking for action on a certain resolution of the A. M. A. in regard to the eyes and ears of school children. Certain literature dealing with this subject is also a part of this exhibit.



## PUBLIC HEALTH AND MORALS.

On the fifteenth day of November last there was held in New York a conference called for the purpose of devising ways and means to suppress conditions and practices dangerous to the public health and morals. To this conference the New Mexico Medical Association was invited to send a delegate and the president appointed Dr. W. R. Tipton, who was notified.

## VITAL STATISTICS.

At the Albuquerque meeting it was resolved that some action should be taken toward the establishing of a Board of Vital Statistics and the secretary was instructed to notify those in authority of the action of the Association. The secretary followed out his instructions and while he is not able to demonstrate that they had any effect in determining the passage of the present law, he is able to report to this Association that a bill passed the recent legislative assembly looking toward the desired end and requiring the registration of all births and deaths.

## MEMBERSHIP.

The following correspondence—Exhibit "F" is brought to your attention in order that you might be posted should the question ever come up. The matter of the application of Dr. J. C. Slack of Clayton is also brought to your attention in order that you might vote intelligently upon it.

Application blanks have been furnished on request to a number of eligible Physicians, but so far, without any further results than appear in the number of applications upon which you will be called to act.

## DEATHS.

It becomes my duty to report the deaths of Dr. S. M. Lane, of Silver

City, First Vice-President; Dr. Joseph Kornitzor of Socorro, and Dr. C. H. Keihl of Albuquerque as having occurred since last meeting.

## BILL.

The secretary herewith presents his itemized bill amounting to \$..... and asks favorable action upon same.

## CONCLUSION.

In conclusion, if this report has seemed lengthy, it is due to the fact that the secretary desires to have the Association pass upon all matters that need attention and at the same time to thoroughly post this House of Delegates upon the doings of the year.

Respectfully submitted,

R. E. McBRIDE,

Secretary.

## PROCEEDINGS OF THE APRIL SESSION.

The Territorial Board of Health transacted the following business during the April session at Santa Fe:

## Licenses Granted.

Physicians admitted to practice are as follows:

Dr. R. Coulson, of Socorro; Dr. L. F. Hummer, of San Pedro; Dr. J. P. Martin, of Deming; Dr. Jose A. Spence, of Silver City; Dr. Solomon Burton, of Albuquerque; Dr. J. P. Roggs, of Puerto; Dr. Shuler Craft of Vermejo; Dr. J. Hass, of Hope; Dr. John B. Frisby, of Raton; Dr. Charles D. Ottosen, of Eris; Dr. Horatio Walker of Cimarron; Dr. J. W. Riecks, of Tucumcari; Dr. E. J. Cowart, of Las Cruces; Dr. David T. Reece, of Hope; Dr. Newton Alfred Seehorn, of Artesia; Dr. E. J. Rowdan, of Albuquerque; Dr. Oliver T. Hyde, of Santa Fe; Dr. J. C. Nichols, of Roswell; Dr. Henry L. Frush, of Watrous; Dr. W. S. Chapman, Dr. F. C. Diver, of Dawson; Dr. J. P. Bonar of Rincon, and Dr. E. S. Millord of Deming.

## County Health Officers.

County health officers were named as follows:

Bernalillo county—Dr. George McLan-dress, of Albuquerque.

Chaves county—Dr. W. Joyner, of Roswell.

Colfax county—Dr. T. B. Hart, of Raton.

Dona Ana county—Dr. C. B. Gerber of Las Cruces.

Eddy county—Dr. F. E. Doepp, of Carlsbad.

Grant county—Dr. O. J. Westlake, of Silver City.

Guadalupe county—Dr. John F. Rudolph, of Santa Rosa.

Lincoln county—Dr. T. W. Watson, of Lincoln.

Luna county—Dr. S. D. Swope, of Deming.

McKinley county—Dr. William Burr, of Gallup.

Otero county—Dr. P. W. Kirkpatrick, of Alamogordo.

Quay county—Dr. H. D. Nichols, of Tucumcari.

Roosevelt county—Dr. T. C. White, Jr., of Portales.

San Juan county—Dr. M. D. Taylor, of Aztec.

San Miguel county—Dr. B. D. Black of Las Vegas.

Sandoval county—Dr. S. G. Clarke, of Bernalillo.

Sierra county—Dr. Frank J. Given, of Hillsboro.

Socorro county—Dr. A. E. Bessette, of Socorro.

Taos county—Dr. T. P. Martin, of Taos.

Torrance county—Dr. William A. Wilson, of Willard.

Union county—Dr. N. E. Charlton, of Clayton.

Valencia county—Dr. William D. Radcliffe, of Belen.

### ROLL OF MEMBERSHIP.

Membership roll of the New Mexico Medical Society corrected to May 18th, 1907:

#### Grant County Medical Society.

G. K. Angle.....	Silver City
E. S. Bullock.....	Silver City
W. J. Hammer.....	Silver City
B. B. Leavel.....	Silver City
Wm. MacLake .....	Silver City
S. A. Milliken.....	Silver City
A. H. Schorman.....	Silver City
F. P. Whitehill.....	Silver City
E. L. Woods.....	Silver City
Karl D. Wood.....	Silver City
Total, 10.	

#### Las Vegas Medical Society.

W. P. Tipton.....	East Las Vegas
E. B. Shaw.....	East Las Vegas
C. H. Bradley.....	East Las Vegas

H. H. Smith.....	East Las Vegas
J. H. Cunningham.....	East Las Vegas
W. P. Mills.....	East Las Vegas
W. B. Kaser.....	East Las Vegas
C. L. Losey.....	East Las Vegas
F. T. B. Fest.....	East Las Vegas
H. W. Coolits.....	East Las Vegas
P. J. Farmer.....	Romero
W. T. Brown.....	Watrous
A. B. Northwood.....	Wagon Mound
Henry L. Pruch.....	Watrous
H. J. Mueller.....	East Las Vegas
B. D. Black.....	East Las Vegas
R. K. McClannahan.....	East Las Vegas
H. W. Heyman.....	East Las Vegas
Fred. C. Clapp.....	East Las Vegas

#### Luna County Medical Society.

S. D. Swope.....	Deming
P. M. Steed.....	Deming
J. O. Michaels.....	Deming
J. O. Moir.....	Deming
R. B. Barbee.....	Deming

#### Dona Ana County Medical Society.

J. H. Burnham.....	Las Cruces
W. C. Field.....	Las Cruces
C. W. Gerber.....	Las Cruces
W. J. Hatfield.....	Organ
J. H. Johnson.....	Organ
E. B. Lane.....	Las Cruces
S. W. Laub.....	Las Cruces
A. E. Lauson.....	Las Cruces
R. E. McBride.....	Las Cruces
T. C. Sexton.....	Organ
Total, 10.	

#### Bernalillo County Medical Society.

W. H. Burr.....	Gallup
D. H. Carns.....	Albuquerque
E. H. Clayton.....	Albuquerque
P. G. Cornish.....	Albuquerque
J. B. Cutter.....	Albuquerque
J. E. Easterday.....	Albuquerque
J. W. Elder.....	Albuquerque
M. A. Fleming.....	Belen
C. W. Taylor-Goodman.....	Albuquerque
G. W. Harrison.....	Albuquerque
W. G. Hope.....	Albuquerque
G. S. McLandress.....	Albuquerque
E. Osuna.....	Albuquerque
F. J. Patchin.....	Albuquerque
J. F. Pearce.....	Albuquerque
J. A. Reidy.....	Albuquerque
L. O. Rice.....	Albuquerque
W. G. Shadrack.....	Albuquerque
W. W. Spargo.....	Albuquerque
J. H. Wroth.....	Albuquerque
M. K. Wylder.....	Albuquerque
W. A. Wilson.....	Willard
E. M. Johnson.....	Albuquerque
J. B. Haynes.....	Albuquerque

**Otero County Medical Society.**

J. R. Gilbert.....	Alamogordo
P. W. Kirkpatrick.....	Alamogordo
B. B. Van Arsdell.....	Alamogordo
C. H. Waldeschmidt.....	Alamogordo
G. C. Bryan.....	Alamogordo
R. I. McNeil.....	Alamogordo
O. W. Miller.....	Alamogordo

**Chaves County Medical Society.**

W. T. Joyner.....	Roswell
J. W. Kinsinger.....	Roswell
R. L. Bradley.....	Roswell
C. M. Yator.....	Roswell
C. M. Mayes.....	Roswell
C. F. Beeson.....	Roswell
E. M. Fisher.....	Roswell
W. C. Buchly.....	Roswell
Z. T. Martin.....	Roswell
D. H. Galloway.....	Roswell
W. W. Phillips.....	Roswell
Jno. A. Farnsworth.....	Hagerman

**Members not members of a County Society.**

R. J. Thomson.....	Santa Rosa
E. A. Jones.....	Raton
J. J. Shuler.....	Raton
T. P. Martin.....	Taos
C. G. Duncan.....	Socorro
W. C. Klutz.....	Tucumcari
C. E. Gayer.....	Raton
H. D. Gibbs.....	Farmington
T. B. Hart.....	Raton
J. F. McConnell.....	Colorado Springs
W. S. Harroun.....	Santa Fe
B. L. Sulsbacker.....	Kansas City, Mo.
S. C. Clark.....	Bernalillo
J. P. Kaster.....	Topeka, Kans.
J. H. Diaz.....	Santa Fe
F. A. Yoakum.....	Cerrillos
W. D. Radcliffe.....	Belen
A. E. Bossette.....	San Marcial
C. J. Amble.....	Manzano
J. M. Shields.....	Perea
H. B. Maston.....	Chico Springs
J. L. Bobbs.....	Raton
A. L. Breeding.....	Texico
J. A. Massie.....	Santa Fe
W. F. Wittwer.....	Los Lunas
Geo. N. Fleming.....	Raton
T. A. Triplett.....	Gardiner
J. C. Slack.....	Clayton
J. Y. Lopsley.....	Van Houton
F. F. Doepp.....	Carlsbad
H. P. Nichols.....	Tucumcari
P. M. Carrington.....	Fort Stanton
W. W. Markoe.....	Fort Stanton
J. B. Greene.....	Fort Stanton

**THE RELATION OF CHRISTIAN SCIENCE TO THE PRACTICE OF MEDICINE.**

(By S. A. Milliken, Silver City, N. M.)

Every year a thousand new pseudo-medical fads, isms, discoveries, treatments and cures are foisted upon an ever-gullible public, every year thousands of people yield up their lives, and many other thousands their health, a sacrifice to the greed of the medical fakir, every year millions of dollars which legitimately belong to the honest, educated physician go into the pockets of these men, whose only aim is to get money,—whose sole knowledge is a knowledge of human nature.

All such deaths are as certainly murders as are those caused by the knife of the midnight assassin, all these millions are as really stolen from the public as though forced from them at the muzzle of a six-shooter, but they are not stolen from us, neither is the respect and confidence of the public which too often go with them. We yield them up voluntarily. For all these wasted lives and this misspent money we as individuals and as a profession are directly responsible.

Did you ever stop to think why it is that people are so ready to flock after these imposters and to spend money with them which they would not think of spending with you,—why the man whom you know to be your friend,—to have perfect confidence in you as a physician, will leave you and go for treatment to these men whom you know to be absolute and unmistakable frauds?

It is because he believes and you allow him to believe, that this vaunted cure is something new, something which is now discovered for the first time, that it is a secret with the supposed discoverer, which you know nothing about, and that you are unable



to gain any knowledge concerning it. It is because you have failed to study and investigate the matter, to prepare yourself to prove to him that it is a fraud and to show him why it is a fraud. It is because you yourself are ignorant in regard to it, and you allow him to find out that you are. It is because you have been shirking your duty to yourself, to your profession, to the community in which you live and to the general public.

We are the natural guardians of the public health, and we should be the instructors and counsellors of the public in every matter which in any way pertains to it. As such it is our duty to inform ourselves promptly and thoroughly on every point which may possibly arise in relation to the attainment, the preservation or the recovery of physical perfection, and not the least important of the subjects on which we should keep ourselves well informed is the subject under consideration—the medical fraud. It is as much our business and our duty to investigate and study them, and to be able and willing to advise and instruct our patrons in regards to them as it is to study and investigate the cause and the treatment of enteric fever and to lay down the proper regimen, and we must be able to do the one as positively and as intelligently as the other. It will not suffice for us to make the unsupported assertion that they are frauds, we must be able to produce good and satisfactory proofs that they *are* frauds. We must know what we are talking about, and be able to prove that we do know.

Now, with this preface, I will briefly consider one of the more recent, widespread and successful of these frauds, Christian Science, which I have selected rather as a peg on which to hang this preface than as a subject for discussion, and in opening the subject I

wish to say that I feel that I speak with some degree of authority, because I have carefully studied the teachings of the cult, and have had exceptional opportunities for observing their practical application in the treatment of disease, and this study and observation has convinced me that, while Christian Science, as taught and practiced by its adherents and advocates is an unmitigated fraud it is based upon and its success is due to an underlying principle of truth, which it would be well for physicians to recognize and study and to apply intelligently and scientifically, rather than unconsciously and empirically as they do at present, or commercially and hypocritically as do the Christian Scientists.

The influence which the Christian Science healer exercises upon the sick man, and which he claims to be a Divine power, is under certain circumstances and up to a certain point, a very useful procedure, and beyond that point and under different circumstances, it is criminally vicious.

This power of influence is one which is exercised every day by every successful physician, who knows it to be a purely human influence, acting through well-understood channels, and the result of a well known natural law, viz: that worry and despair act through the nervous system to depress the vital powers and to derange the mechanism of the physical processes, and to vitiate their products, while hopefulness and cheerfulness stimulate the organism, replacing these poisonous products with a vitalizing, health-giving flow.

The viciousness of the teaching lies in the fact that it leads the patient and his friends to depend upon a supposed omnipotent, divine power, which can be exerted only through the will of the healer, when in reality, the healer

exerts only a human influence which every human being possesses and may exert at will, while the power, such as it is resides solely in the patient himself and can be exerted by him alone.

This power, it is true, is useful as an aid in directing back to its natural channels the diverted stream of life, especially in the earlier and less critical stages of its diversion, but is wholly inadequate to control the full flood, or to repair the broken dykes which should confine it to its normal course.

This then is what the physician should know in regard to Christian Science, *and he should see that the public, his public, knows it, too*, not because he asserts it, but because he is able to demonstrate to them that it is true. And like knowledge he should have in regard to every other similar scheme, standing as a sentinel to warn his flock and to guard them against the attacks of these wolves, prepared at every new assault to tear off the new disguise and show them up in their true character as foes to humanity.

#### THE WISE GENERAL PRACTITIONER AS A FACTOR IN THE PREVEN- TION OF TUBERCULOSIS.

(By C. W. Taylor-Goodman, M. D., Albuquerque.)

According to the Dictionary, the adjective, wise, means having the power or faculty of discerning or judging correctly; discreet, sagacious, prudent, sensible; learned, erudite, enlightened, etc. Therefore, the wise physician "knows his business." Mayhap he would require a little help from his specialist brother to determine the opsonic index of a given case, but he detects readily the earliest symptoms of departure from health in the children of his clientele, and directs his efforts towards their correction. He knows that the delicate child with narrow chest, drooping shoulders, promi-

nent scapular, long, oval face, thin, fine hair, thin skin, and markedly bright eyes with a bluish tint to their sclerotic membranes is more likely to develop Tuberculosis sooner or later than the child of opposite developmental habit. The connection between infection in infancy and the development of tuberculosis in later years is generally acknowledged; those who escape in childhood rarely develop it.

Formerly the child with enlarged cervical glands was called "scrofulous" and, as such children were often very precocious the laity looked on with complacency.

Now, the term tuberculous adenitis and the significance of the condition is understood by the people generally: Thanks to the Doctor! He teaches that tuberculosis is an infectious disease, whose extent of development and course depends always on constitutional conditions. Since every human being *may* be infected, and since only a comparative few develop the disease, it follows that tissue resistance must play an important part in deciding the matter. Since it is established that alcohol destroys the integrity of nerve fibres he knows that degeneration of the pneumogastric nerves may bring about the condition of lung substance which favors pulmonary consumption, because degeneration of a nerve implies degeneration of the organ which it supplies. Therefore, he teaches that the too free use of alcohol is to be avoided. He teaches the importance, the necessity of a proper diet; proper in quantity as well as quality. He insists that children be required to eat a proper proportion of flesh and fat forming foods. After a time the children will have acquired a liking for the valuable foods preferring them to dainties. Life is largely a matter of education and environment supple-

menting heredity. This last factor is beyond our influence in the present generation but one can do much to overcome an adverse heredity by education. Therefore he teaches that a human body is built up and maintained by the food taken, and, that, like a house, if the material used in building is poor the result will be unsatisfactory. He emphasizes the necessity of pure air in unlimited amounts night time and day time; and the necessity of correct breathing, normal chest expansion and poise of body. He advises well directed gymnastic exercises, brisk walks, personal cleanliness both physical and moral, plenty of sleep and the development of a cheerful habit of thought. He teaches optimism, and recommends looking on the bright side of matters as well as walking on the sunny side of the street. He insists on thick-soled shoes, comfortable-fitting clothing, warm in winter, cool in summer; short skirts for women. Furs, if worn at all, used for leggings *not* around the throat.

In the dressing of young children he emphasizes the need of a practically uniform temperature of the body and extremities, since local chilling means congestion somewhere else in the person. The abdomen should always be well covered, best with soft flannel.

He demonstrates to his country patients the utility of good drainage; of cleanliness in the dairy and other buildings, and of the proper housing and feeding of good stock. He warns stone-cutters, cement-workers and millers of the dangers that attend the inhalation of the varieties of dust to which they are particularly exposed. He advocates the pneumatic sweeper for removing dust from hotels, school-houses, clubs, churches, factories, post-offices, restaurants and other buildings much used by the public; the moist

cleaning for homes; the sprinkling of city streets, and also all others means which tend to lessen air Contamination.

He suggests sanitary ordinances, and laws to compel the heedless element to care for and properly dispose of sputa and other excretions; to secure proper sanitary buildings, street cars and steam cars; proper water supply and sewer systems in cities. Also sanitary supervision of dairies, markets, bakeries and milk depots, etc.

This sketch of the wise Doctor's usefulness is of necessity brief and incomplete—always his work is for the betterment of humanity, with a sublime disregard of his personal interests, and perhaps in no other way does his work show such satisfactory results as in the prevention of the disease we call Tuberculosis.

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#### PHTHISIS AND PREGNANCY.

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Burkhardt (Deutsch Med. Wochenschrift) concludes: 1. Pregnancy does not ipso have an unfavorable influence on the course of tuberculosis of the lungs; cases do well at times in high altitudes. 2. Cases of progressive phthisis can become stationary during a pregnancy and the progress is then favorable. 3. Abortion does not benefit the lung condition; on the other hand, it might do much harm. Artificial abortion must, therefore, be limited as far as possible, and the indications which the author is inclined to give are as follows: (a) The severest form of phthisis, and (b) when hyperemesis gravidarum exists. 5. At the birth emotional excitement and bleeding must be reduced to the lowest measure possible, suckling must be forbidden. 6. The treatment of the phthisis in high altitudes must be continued for from four to six months after the delivery, even in mild cases with favorable prog-



nosis, in order to avoid late disturbances.

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#### DEATH OF MR. THEODORE D. BUHL

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We were pained to learn of the sudden death on April 7th, of Mr. Buhl, president of Parke, Davis & Co. The following is a copy of a memorandum adopted at a recent meeting of the company:

"Ten and a half years ago Theodore D. Buhl cast in his lot with this house. Throughout that period he has given us the benefit of his large experience, his sound judgment, his great power in the commercial world, his granite credit reared on an unwavering honesty. As President of the house he was the perfect type of integrity and fidelity to all the stockholders. His high sense of duty as a trustee pledged to administer the property and guard the interests of others, was ever uppermost in his thoughts. The peculiar responsibilities and hazards of our work—our obligations as purveyors to the medical profession and to suffering humanity, were to him always a solemn appeal. The ultimate triumph of character in business was with him a conviction as deep and strong as instinct. The remote future and the distant prize concerned him more than the present gain.

The strength which he gave this house and all the many enterprises in which he shared, signally exhibits what the world should realize especially at this hour—that rich men of unflinching honesty and sound judgment are of inestimable value to their communities. They are the employers of labor, the authors of new industries, the creators of new values, the pioneers who open up vast avenues of opportunity for their followers. As they succeed or fail, the comfort, the very

bread of thousands is assured or endangered. We hear much these days of unscrupulous, predaceous wealth, but what of the type of Theodore Buhl—what of the men who consider the trust of their fellow men the best of their possessions, who have a horror of stock-jobbing methods, who never seek an unfair advantage, who never lend their names to a dubious enterprise?

As a director, Mr. Buhl was the soul of courtesy, kindness and deference. As an employer he was considerate, thoughtful, mindful of the comfort, interests and claims of his employes. To their grievances he gave always a patient and attentive ear. He encouraged the manly expression of honest opinion, and when it differed from his own his effort was to convince and persuade, not to invoke his authority or impose his will.

On behalf of the stockholders, employes and executives of Parke, Davis & Company we record this testimony to the lasting service rendered us by our lamented President. To the members of the bereaved family we offer our warm and heartfelt sympathy. May strength be theirs to bear their sorrow. May they find much comfort in the memory of a life rich in well-doing and in good repute."

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#### MEDICAL ERA'S SPECIAL EDITIONS

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*The Medical Era* of St. Louis, Mo., will conform to its usual custom and issue its yearly series of special Gastro-Intestinal numbers embracing July and August. The August issue will be given over entirely to the consideration of every phase of Typhoid Fever. The series will contain about 35 or 40 practical papers and will contain a large amount of valuable information.

One Henry C. Post of Grand Rapids has a grouch. In his article entitled "In the Land of the Grafters who Prey Upon the Hopelessly Ill," Grand Rapids Post, May 18th, he would lead the unwary to believe that the Great Southwest is a "Godforsaken desert," inhabited only by leeches and lungers. He admits we have a little sunshine, and that he grabbed a handful of health here and there, but warns the other fellow with a cough to stay in Grand Rapids because "there is no escaping the omnipresent, sinister evidences of the pernicious plague," and because, "the cadaverous, coughing specters, the portable paper cuspidor, the nocturnal wagon of death" are all here.

While we agree with Mr. Post in his advice to the poor and hopelessly ill, we are prone to believe that he looked upon other matters through the wrong pair of glasses. Because one Los Angeles physician happens to have been a "vulture" and "got his vampire claws" on Mr. Post at \$10 per, we hardly think it fair to brand the "Western physician a heartless grafter."

In the meantime, thousands are still glad to accept our sunshine and health restoring climate, our conditions and society, and when they get well and go home feel grateful enough to boost though an opportunity to use a little hammer and have their pictures in the papers may be afforded them.

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The meeting held at Las Cruces, May 8th and 9th, was one of the most successful in the history of the New Mexico Medical Society. Nearly all parts of the Territory were represented, delegates from all county societies being present.

The House of Delegates organized promptly and a large volume of busi-

ness was transacted in a short time. The scientific programme was complete, and no livelier discussions have been heard at our annual meetings.

The Dona Ana County Society is to be congratulated upon the entertainment furnished, the banquet at the Don Bernardo and the ride over part of the beautiful Mesilla valley following the meeting being most enjoyable.

The following members were in attendance:

Drs. G. W. Harrison, Albuquerque; S. D. Swope, Deming; Geo. C. Bryan, Alamogordo; G. S. McLandress, Albuquerque; Geo. K. Angle, Silver City; C. W. Gerber, Las Cruces; A. E. Lauson, Anthony; W. J. Hatfield, Organ; Sol W. Laub, Las Cruces; T. C. Sexton, Las Cruces; F. T. B. Fest, Las Vegas; W. C. Field, Las Cruces; B. E. Lane, Las Cruces; C. W. Taylor-Goodman, Albuquerque; Chas. D. Duncan, Socorro; T. B. Hart, Raton; S. Milliken, Silver City; E. Bullock, Silver City; J. H. Johnson, Organ; J. P. Kaster, Topeka; E. D. Strong, Hanover; J. L. Burnham, Las Cruces; H. D. Nichols, Tucumcari, and Drs. James Vance, B. F. Stevens, and W. H. Pickels, of El Paso, Tex.

A full account of the transactions of both House of Delegates and General Assembly is printed in this issue.

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Dr. T. J. Coffey, the genial obstetrician of Los Angeles, recently stopped over at Albuquerque for a few days. When he decided to continue on his journey, he called up the ticket office and asked, "Have you any report of berths on number 4?" "No," was the reply, "who is this?" The doctor gave his name, which seems to have been sufficient, for the agent replied, "Well, doctor, I will telegraph ahead and try and arrange for one."

April 1st, *The Journal of Ophthalmology and Oto-Laryngology* issued its initial number. It is to be published monthly and is under the editorial control of Drs. Willis O. Nance, and Albert H. Andrews.

Well known specialists contributed the following original articles for this number:

The Treatment of Serpent Ulcer of the Cornea—H. W. Woodruff, M. D., Joliet, Ill.

Headache and Eyestrain—L. Harrison Mettler, M. D., Chicago.

Antepartum Purulent Conjunctivitis—Willis O. Nance, M. D., Chicago.

The Submucous Resection of Deflections of the Nasal Septum—Otto T. Freer, M. D., Chicago.

Trans-illumination of the Mastoid—Albert H. Andrews, M. D., Chicago.

#### BOOK REVIEW.

(A practical handbook of *Materia Medica and Therapeutics*, based upon established physiologic actions and the indications in small doses. By Thomas S. Blair, M. D. Over 250 pages, bound in limp library cloth. Price \$2.00 net. Published by the Medical Council, 4105 Walnut Street, Philadelphia, Pa.)

Dr. Blair, a regular physician of very high standing in his profession, has made a close study of the *materia medica* and *therapeutics* of each of the sectarian schools, has for many years tested their methods and remedies in his extensive practice, and has carefully noted in each one that which every practicing physician should know and be able to adopt in his practice.

Though the fallacy of dosage as taught by some of the sectarian schools is discussed, the book does not stir up prejudice, but clears up many of the difficulties in the way of a truly rational and, above all, a highly successful practice of therapeutics.

It is a neat little volume and we pre-

dict that it will become the desk companion of all who purchase it.

#### BOOK REVIEW.

(*The Principles and Practice of Dermatology*, by William Allen Pusey, A. M., M. D., Professor of Dermatology in the University of Illinois; Dermatologist to St. Lukes and Cook County Hospitals, Chicago. Member of the American Dermatological Association. 1022 pages, with one colored plate, and three hundred and sixty-seven text illustrations. D. Appleton and Company, Publishers. Price in cloth, \$6.00.)

An up-to-date and most important publication.

Recognizing the fact that it is highly desirable in any study to be fully acquainted with the fundamental knowledge of the subject in order to obtain a satisfactory grasp of the special diseases, Dr. Pusey has given considerable space to THE PRINCIPLES OF DERMATOLOGY, ANATOMY AND PHYSIOLOGY OF THE SKIN, GENERAL ETIOLOGY, PATHOLOGY, SYMPTOMATOLOGY and TREATMENT OF DISEASES OF THE SKIN.

The work is most exhaustive, yet practical and the GENERAL TREATMENT especially has been considered in full.

The text of the work is particularly clear and lucid, and the illustrations are, we believe, the best that have ever appeared in a book upon this subject.

The contents of the volume is divided into sections upon the following subjects, all of which are dealt with in an interesting and comprehensive manner.

The Principles of Dermatology.

The Practice of Dermatology.

Angionurotic Dermatoses.

Inflammations.

Dry Scaly Inflammatory Dermatoses.

Hemorrhages.

Infectious Diseases of the Skin.



Infectious Diseases of Typhomycetic Origin.

Dermatoses Due to Animal Parasites.

Dermatoses Due to Parasites which Penetrate the Skin.

Hypertrophies.

Atrophies.

Anomalies of Pigmentation.

Neuroses.

New Growths. Benign Neoplasmata, Malignant Neoplasmata.

Diseases of the Appendages of the Skin.—Diseases of the Sweat Glands, Diseases of the Sebaceous Glands, Diseases of the Hair, Diseases of the Nails.

Diseases of the Mucous Membranes.

The following extracts from report of Dr. J. N. McCormack, chairman Committee on Organization read at the Atlantic City meeting, June 3rd, will be of interest to all our members:

#### DEVELOPMENT OF COUNTY SOCIETIES.

Taking up matters in the order of their importance, I desire to urge on the House of Delegates the paramount duty of fostering care in the work of county societies, the foundation and hope of our organization. In my last report I referred briefly to the serious conditions which have confronted councilors and other workers since the exhaustion of the first outburst of enthusiasm following the reorganization movement in maintaining the interest in these societies. Outside of the large centers of population it has been found practically impossible to do this under the old order of programs, with textbooks, papers and routine discussions at monthly, bi-monthly or quarterly meetings. The plan for systematic postgraduate instruction, originating in the minds of thoughtful workers of widely separated sections, acting quite

independently of each other, to meet this difficulty, found such favor that it spread rapidly and is now in more or less satisfactory operation in many counties in several states.

#### POST GRADUATE COURSE.

Believing that there are almost unlimited possibilities in this scheme as a means of inducing both young and old members to continue or to revive their interest in scientific medicine, and that there are few physicians anywhere who would not be benefited by such a review course, the committee has induced Dr. J. H. Blackburn, Bowling Green, Ky., who has been a leading spirit in conducting a course in his own county society, to elaborate a tentative plan covering a four years' course of study, adapted to the needs of the average county society. This has been printed, with an explanatory letter from Dr. Blackburn, for submission to you first, and then to send to active, carefully selected workers in every section of the country, with the hope of eliciting helpful criticisms and suggestions. If the plan meets your approval, after profiting by such criticism as may be obtained, it is expected that the outline for the entire course can be revised, printed in pamphlet form, and put in the hands of the county societies at an early day, so that the teaching work may be assigned to members, and that the weekly course, elaborated somewhat after the university extension idea, may begin in the Journal of the Association and the monthly journals by the first week in September.

While it is hoped, in the course of time, to make this so attractive that a majority of county societies and physicians all over the country will be engaged in the same line of study, it should be borne in mind that the course

is purely suggestive. Stimulated by what we propose, it is hoped and expected that many societies, especially those in the educational centers, will suggest something far better, and that out of all of them may be evolved something so nearly ideal that by the second year, or at least by the second cycle, it can be utilized in any community where as many as three or four members can be gotten together each week, or even as a course of home study by those less fortunately located.

After the course is well under way, if it proves as practical and successful as is anticipated, it may come about that county societies will be asked to appoint committees and conduct examinations on blank forms furnished, probably at home under an implied pledge not to seek text-books or other aids, something after the Chautauqua idea, and that a certificate will be provided, all free of expense, to those who take the course to the satisfaction of their county society. The necessity of doing something in this direction, and the magnitude of the problem, will be appreciated when it is known that a large majority of the 122,000 licensed physicians who are treating sick people every day do not attend medical meetings, and that a large per cent. of this element do not read recent periodical or standard literature. I am convinced that this is entirely practical, that excellent teaching can be developed in a majority of the county societies with little or no outside aid except from the councilors, printed matter, and weekly elaboration in the journals, and my idea is for the Association to take the work up in a comprehensive way and to prosecute it year after year, until, with co-operation of the Council on Education and state boards, a competent, up-to-date physician has been placed within the reach

of every family in the United States. It will probably require about six hundred dollars (\$600) annually to meet the expenses incident to the preparation of this course, and I suggest the appropriation of this amount or so much thereof as may be necessary, to be expended under the direction of the Secretary.

Meeting and discussing matters of common concern with the rank and file of the profession of widely separated sections in a frank heart-to-heart way from month to month, as well as through the extensive correspondence of my office with county society and other officials in every part of the country, I have been able to study and weigh professional conditions and sentiment on nearly every matter of general interest in a very broad way. As I have talked to lay audiences in the evening, after meeting the profession in the afternoon at almost every appointment, I have also had an opportunity to gauge public opinion in regard to our work in a comparative way from year to year.

As a result of this large experience and study, I am gratified to report that in its essential features our system of organization has constantly grown in trial, and is no longer considered an experiment anywhere. I have often met the honest, intelligent, healthy criticism and inquiry as to methods, details, and have courted and encouraged this spirit as not only legitimate, but most hopeful and helpful. The constant growth in harmony, in confidence in itself and in power over public and legislative opinion, even more noticeable than the gain in membership, which goes steadily on from year to year in nearly every state, are so evident as finally to convince most of those who were long naturally doubt-

ful as to the wisdom of the change of methods.

In fact, I have been constantly both surprised and gratified to find how few, except those commercially interested have been misled by the active and adroit crusade of the proprietary medicine people and their allies. The journals directly controlled by them have been made to serve their masters with only such regard for truth and decency as would best carry out the purposes for which they exist. With that element of the so-called independent, but really most dependent, medical press, indirectly controlled by the same interests, probably some time without being fully conscious of it, it is more difficult to deal, although it is often hard to distinguish between them. Many of these editors are good men who want to be loyal to the best interests and traditions of the profession, but, living in a commercial age, and accustomed to receiving revenues from the same advertisers until it had become second nature, and seemed almost essential to their existence, they were blinded to the importance of the drug reform which has swept over the profession and country like a tornado. Iterating, reiterating and repeating by quotations from each other the pure fabrications, or worse insinuations, and innuendoes, evidently all having a common origin, these journals, paid for by somebody, have flooded the desks of doctors all over the country like the leaves of autumn. They might have created distrust even in our membership had not their vehemence been too loud and insistent to be disinterested, and because nearly all of their stories bore unmistakable ear-marks of their common mercenary paternity. I desire to emphasize that what is said here does not apply to those journals, under whatsoever management, which

are making faithful efforts to foster scientific medicine and to free their advertising columns from objectionable matters. On the contrary, these are entitled to and should receive not only the cordial moral, but the financial support of the profession.

While these misrepresentations have done so little harm with the membership, I am convinced that they have kept many from joining the societies and have crippled our usefulness in many other ways. As one evidence of this, they have arrayed the retail druggists against us almost solidly in most states. At every capital visited I have found a strong force of drug men working under the direction of expert lobbyists representing the National Association of Retail Druggists, backed by the proprietary interests, against the legislation proposed by the profession in the interest of pure food and drugs, with all of their expenses borne by that body. In every instance an attempt was being systematically and often successfully made to confuse the minds of legislators by the introduction of decoy bills prepared by their central bureau, but cunningly altered as to wording in the various states to hide their common origin. It was found in every instance that legislators were also literally inundated by letters and telegrams from their drug and newspaper constituents in the interest of these now fully exposed and recognized frauds. As a real friend of the pharmacists, one who has always been wedded to the prescription method of dispensing, the discovery of this almost universal ascendancy of the quack interests over this trade was a painful one. It evidently means that we have come to the parting of the ways with the druggists, and must arrange to dispense for ourselves, as is being done in other countries, unless prompt steps



are taken in a comprehensive way to restore proper relations with them.

For these and others reasons, the time has come for this House to meet frankly and once for all to set at rest the issues raised by these people or by anybody else who has criticisms to offer. Everything so far proposed for improving our methods was threshed out and rejected in framing our organization, but there is nothing about the plan, its purposes or its personnel which is not subject to fair criticisms and discussion. Most of your officers serve gratuitously, and some of them have given the best years of their life in this way. This is also true of the executive boards, which are arousing so much opposition because they are doing fearless and admirable work. You have but two salaried officials. I am one of these. Paid or unpaid, we are all your servants. Speaking for myself, although I know that I may speak for all, I ask you to investigate, criticise and condemn, if you will, but let all who have complaints or doubts speak out in open meeting as candidly as I do in giving the results of my work, in which, although I hold my position by your partiality, I have always felt the utmost freedom. Half of the members of this House have served in it for at least one year, some like myself for several years, and the other half are fresh from their constituencies, to whom and our consciences all of us are alone responsible. All have equal interests, rights and powers, and if any are dominated by improper motives or influences it is a reflection on either their integrity or their intelligence. I am satisfied that no such influence has ever been exerted or attempted, but it is your duty to satisfy yourselves if there be any question in your minds. Let us take up all of our work in this kind, frank, dispassionate

way, remove the causes of complaint, if any exist, remaining here for ten days or two weeks, if necessary, to do it all thoroughly, and return home with such foundations laid for so much better work that it will make our profession the powerful factor in its own uplift and in public affairs which is demanded for the welfare of those we serve, bearing in mind that we are the real official Medical Congress of these United States.

#### STATE MEETING TO BE HELD IN THE FALL.

For the reason here set forth, and for others still more important, it is again urged that all the state associations which have not yet done so, seriously consider the advantages to be gained by holding their meetings in the fall, as nearly as may be, midway between the meetings of this association. A number of state associations have already acted favorably on this suggestion and the advantages of the arrangement are evident. With the state and national meetings coming within a few weeks of each other, as is often unavoidable when both are held in the spring, many of our best members are forced to miss both of them. In addition, and probably more important, half of the delegates from such states begin active service at once without the time for such inquiry and study as would make them most useful to their constituents and to the cause of organization.

The committee realizes that the matters embraced in this report are important and far-reaching, and that it may be several years before some sections will be ready to organize branches. On the other hand, other sections with long established strong societies are ready and anxious to come into such relations with the system as

will make them valuable factors in the scheme of organization, and some of these have had formal applications for such relations pending for several years. Instead of increasing it would really tend to diminish the number of societies, as there are already two or more organizations in almost every section indicated for a branch, and some of them semi-national in scope or claims, and all of them overlapping each other in such a way as to produce inextricable confusion. We only propose a plan or framework for such an orderly growth and development as will bring an occasional stimulant to the scientific work of each state society without a possible interference with its official proceedings, furnish an opportunity for the recognition of the large and growing class of worthy men, especially the younger men, who, in consequence of our rapid growth, find it more and more difficult every year to get on the program of the section, and, at the same time, to make the branches feeders and culture beds for developing higher work in these sections.

If the recommendations are approved nothing hasty or ill-considered can result, as the whole question as to each branch or participation therein, is conservatively left to the state associations composing them, and membership is made voluntary, and is limited to those who are members of their respective county and state societies.

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#### HUMOROUS.

---

"A little nonsense now and then,  
Is relished by the wisest men."  
—Anonymous.

#### IN THESE DAYS.

The Nurse—I hope you don't blame me for the baby's illness.

The Doctor—I certainly do. You should know better than to leave it

alone in the care of its mother for even a moment.—*Ex.*

---

#### A GRAFTER.

Mrs. Bill—"Do you think that skin-grafting operations by Dr. Doemall will prove a success?"

Dr. Bill—"Why, most assuredly. He's one of the most noted grafters in the profession."—*Judge.*

---

#### CREDITABLE.

A village doctor whose most troublesome patient was an elderly woman practically on the free list, received a sound rating from her one day for not coming when summoned the night before.

"You can go to see your other patients at night," she said, "why can't you come when I send for you? Ain't my money as good as other people's?"

"I do not know, madam," was the reply; "I never saw any of it."—*Chicago Med. Recorder.*

---

#### MORE EFFECTIVE.

"Moike?"

"What is it, Pat?"

"Shposin' Oi was to have a fit?"

"Yis."

"An' yez had a pint av whiskey?"

"Yis."

"Would yez kneel down an' put the bottle to me lips?"

"Oi would not."

"Yez wouldn't?"

"No. Oi could bring yez to yer fate quicker by shtandin' up in front av yez an' dhrinkin' it mesilf."—*Ex.*

---

The addition of sugar to castor oil makes it more palatable without lessening its activity. Brown or maple sugar is best.—*Medical Council.*

**Erysipelas of the Face.**

In this condition Dr. Tison advises painting the affected part with a saturated ethereal solution of camphor. This acts as a sedative, and rapidly relieves the pain and inflammation. The application may be repeated as often as necessary. Obviously its inflammable nature calls for precautions. — *The Dietic and Hygienic Gazette*.

**Ice Pack.**

Place the stripped patient on a mackintosh sheet. Fold an ordinary sheet in four layers, and fill in between layers with powdered ice. Wrap around body, leaving limbs free and axillae accessible for the thermometer. — *The Clinical Review*.

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## CONTENTS

Orthotic Albuminuria and Its Relation to Tuberculosis.....	5
Scarlatinal Sore Throat .....	18
Primary Tuberculosis of Caecum and Appendix. Report of Case.....	24
An Appeal to the American Medical Profession .....	27
Book Review .....	30
The Obliquity of the Religious Press. ....	31
Bye-Bye, Bye .....	32
Physicians Granted Licenses.....	33
The Use of Adrenalin During Ether Anesthesia .....	33

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# ORTHOTIC ALBUMINURIA AND ITS RELATION TO TUBERCULOSIS.\*

(By Francis T. B. Fest, M. D., Las Vegas,  
New Mexico.)

The term "albumin" as used in medicine, has become falsely synonymous with protein, therefore, albuminuria signifies the presence of protein and proteoses in the urine. I include the whole group because an exact distinction is impossible. We have to deal with about eighteen related bodies; the recognition of which, by our present chemical reactions, is imperfect and impossible. Only the ferment reactions of Emil Fischer, or the color tests of Landsteiner, Ehrlich, Gieseler and others give true distinctions.

For this reason I comprise in this paper under albuminuria, all proteinurias.

Nor am I satisfied with the term "orthotic" or "physiologic" albuminuria. The cry for a name is as ardent as when Merklen asked: "What name"? I adopted the term "orthotic" as suited to express best the diminution of the proteids during recumbance in most of the cases observed for which manifestations, terms were adopted such as: "orthostatic, postural, intermittent, transitory, functional, physiologic, cyclic, latent, essential, emotional, etc."

To understand better the evolution of our present knowledge on this subject, I give a history of the most important early contributions until the modern epoch initiated by Leube.

In 1786, Fordyce stated that urine contains serum and coagulable lymph. In 1788, Cotugni recognizing albumin by boiling, and taking same as identical with egg-albumin, began a misnomer from which we seem to have been unable to find riddance. Up to Spittal, all albuminuria was connected with dropsy or Bright's disease and no dis-

tinction was made until Desir in 1835 first described a transitory albuminuria, followed in 1838 by Solon who distinguished between coagulable and precipitable albumin.

Osborne and Willis contributed in 1840, and Christisen found it first in the healthy; and Becquerel in 1842, "without the slightest reason". In 1843 Prout declared its presence to be normal. Graves and Abeille found in the same year no connection with renal disease. In 1844, Rayer and in 1846 Malmsten. Hoeffle found it in 1848 also in the healthy. Walker-Delarelle, in the same year. In 1849, Abeille. In 1850, Ravin, Frankel, Ravoth. In 1851, Moser, Strahl, Frerichs. In 1852, Simon considered its presence as pathogomonic; further Beneke, Rees, Begbie. In 1853, Heintz. In 1854, Guber, Leyden, Munk. In 1855, Zimmerman. In 1856, Neubauer, Vogel, Traube, Becquerel, Vernois, Huppert, Balfour. In 1857, Skoda. In 1858, Oppolzer, Gigan, Bernard. In 1859, Thenard. In 1860, Valentiner, Koerner. In 1861, Ziegler, Hamon. In 1862, Stokvis, Mannkopf. In 1863, Rosenstein, Wundt, Stokvis, Abeille. In 1864, Smoler, Coroisart, Schiff, Dupuytren. In 1868, Dohrn, Gerhardt. In 1869, Pollok. In 1873, Kjellberg, Jackson. In 1874, Huppert. In 1875, Semmola. In 1877, Leube.

Prout had relatively few followers who considered albumin a normal constituent of the urine: only Washburn, Posner, Malfatti, Dwight, and lately Senator. Simon naturally also found strong advocates: Balfour, Millard, Fulton, West, Brunton, Plosz, Winternitz, Jasiewicz and to a certain extent Talamon, Decorche and Sturgis. Osler said, that the presence of albumin in the urine in any form and under

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any circumstances is pathologic. Tunis cannot consider the individual healthy; neither can Curschmann. Aubertin claims these cases to be manifestations of a terminal nephritis, while Long, Sorne, Bennett, Clark, Wittington, Chabrely, Porter, Cuffer and Gaston seem to recognize a prodromal stage of nephritis.

Contributions about albumin in the healthy came from the pens of: Christisen, Hoefle, Becquerel, Edlefsen, Gentzen, Ruttan, Munn, Octerlony, Leube, Peterssen, Taykull, Erlanger, Willis, Ewald, Hauser, Anders, Boston, Klemperer, Johnson, Poesner, Richter, Chateauborg, Misiewicz, Capitan, Finot, Mesnard, Lantos, Westmoreland, Pavy, Tyson, Saundby, Giardner, Eddison, Germain, See, Berzelius, Huger, Meigs, Ellis, Kelly, Ziffer, Fox, Brunton, Buignies, Edwards, Filipowitch, Caille, Ott, Moxon, Duke, Lucas, a. o.

Semmola declared it merely a symptom. Zeehuisek found albumin in 28 per cent of his examinations without apparent lesion. Stuart's statistics of 505 healthy show albumin in one-third; similar results had Charles and Stokvis. Moore in 6 per cent. Zeehinsen and Noosden claimed albumin for 60-68 per cent of all their examinations.

Cabot found in the autopsies of twelve cases, which had albuminuria during life, no lesion. Stengel believes that the significance of traces of albumin is generally exaggerated.

Musser says that albumin is no indicator of any disease of any organ, nor does it point to any general pathologic condition.

In fact, examiners for life insurance were especially interested in this question and took such views. Munn found albumin in 11 per cent of the examined. Symond's report of 3,000 declined ap-

plications shows no influence upon prognosis. Pavy, Sir William Roberts and Clement Lucas recognize the insignificance. (Contributions: Munro, McGraw, Hitchcock, Stoner, Miner.)

At the Life Insurance-Medical-Officers-Association meeting in London in 1894, Thompson accepted transient albuminuria as a harmless manifestation and was supported by men like Heron, Pollock, Hoar, Olgivie, Hungston, and Fox. Some like Hall, Purdy, Breen, Wood, Rothrock, Lecorche, Talamon, Porter, Bickerton advise against such as risky. At last year's Congress of Insurance Examiners, Fox stated the possibility of a harmless form of albuminuria due to hematopoietic conditions.

The fact, that we have no generally recognized name for the condition under discussion, a manifestation for which Ellis gave one hundred and fifty causes, make understanding difficult. The following terms had been given: "Intermittent" by Ott and Weidenfeld. "Transitory and transient" by Kinnicutt, Rayer and Rumberg. "Cyclic" by Von Noorden, Pavy and Weidenfeld. "Functional" by Raabe, West and Barrs. "Physiologic" by Leube. "Latent" by Gerhardt, "Emotional" by Filipowitch, "Essential" by Neukirch. "Orthostatic" by Gillet. Smith speaks of an "Albuminous diathesis." Hamon coined the term 'Albuminurric neurosis'. Tessier and Casper even accepted a disease "sui generis". These terms are partly referring to causative factors, yet one manifestation is to a more or less de-present in all. Namely: in horizontal position the albumin disappears; after assuming an erect position or sometimes after the least exercise the albumin is increased. Under above terms



cases have been described which were truly orthostatic and no other causative factor can be recognized.

I mention the most typical: Long: a woman who was always free of albumin in the morning. Harringham: a male aged 13. Mortiz: a lad of 17; whenever in erect position, the albumin appeared; to disappear again after assuming a horizontal position. Lunis: a boy of 12 years. Neukirch: a child of 10 had these manifestations for five years. Tiemann: boy of 15. I hesitate to accept Kennedy's and Heubner's cases as true orthostatic, because the former succumbed later to nephritis and the latter had brain tumor and pulmonary lesions. Other typical cases were reported by Schmidt, Heymann, Davis, Archard, Mery, Touchard, etc.

Studying the majority of the cases reported under the beforementioned terms, it is astonishing to note a similarity to the cases just referred to; a similarity which induced me to accept the term "orthotic" as general.

Filipowitch called his case "emotional." In the description we see that the urine was normal in the morning. Mendel and Huger call their cases "cyclic". They mention the fact that the urine was normal after a night's rest. Gubler as far back as 1854 noticed no albumin in the morning. Guyon observed that motion increased albuminuria. Symonds, Tiemann, Kelly, DaCosta, Capitan, Finot, Richter, Mason, Heubner, Loeper, Chateaubourg did the same. Balfour in 1856, and later Huger noticed the difference after change of posture. Pavy, Roberts and Lucas for these reasons advised that the urine be examined for life insurance at different hours, and at least four times daily.

Our knowledge of the proteins is imperfect. We have to deal with compli-

cated molecular structures. (Cohnheim).

In our attempt to understand the exact nature of these proteinurias, we have not progressed very far. In fact, we just begin, since the experiments of Emil Fischer succeeded in constructing albumin synthetically, to feel that our task is harder than we thought, and that all classifications of albumin albumoses, etc., are faulty. We have to do with amino complexes of over thirty acid chains. The recognition of a multitude of bodies is old, since Solon. Balfour claimed the albumin in the postural albuminuria to be pus. Oppolzer and Hauser differentiated albumin with casts and without such, a distinction which until lately was by many considered to be of great value, while they overlook the fact that the presence of casts is a symptom of local renal pathognomy.

Brunton did excellent work. He excluded serum albumin from that of functional manifestations as not sufficiently diffuse. Later on he and Power tried to differentiate several kinds by their coagulation point. Patton was able to separate by dialyzation a body of crystalline globulin. Semmola lays stress upon the fact that albumin of functional appearance are dialyzable. The experiments of Bernard that egg-albumin in its original form could be demonstrated in the urine after venal injection, while blood serum could not be detected, was taken as a standard; and the additional fact that albuminoid bodies, obtained from the urine, injected into other animals appeared again in the urine, spoke for the later tendencies. (Pepper).

Stokvis spoke of acid albumin. Many like Csatory, Carter, Pichler, Vogt and others see special forms of albumin for the orthotic manifestations, mostly

nucleo-albumin. Moerner claims this nucleo-albumin to be a combination of serum-albumin with chondroitin, sulphuric, nucleinic or taurocholic acid. Langstein claimed that orthotic albumin can always be precipitated by acetic acid.

Senator in his famous monograph on albuminuria defines urine a product of transudation which normally contains a certain amount of proteids like all transudation fluids, and that this normal amount can be increased in such quantity to the production of what Leube calls "physiologic albuminuria". This statement called for an animated controversy, mostly with the French school, especially Lecorche, Talamon, and Jasiewicz. Winternitz and Plosz took the same stand.

Accepting and enlarging the hypothesis of Senator, we must search for an explanation of how the proteins reach the urine and where they come from; even admitting that minute quantities of some form be normal; what are the factors of increase of amount?

As far back as 1861 Semmola taught that the diffusible albumin in the circulation must be secreted by the urine. Later he said that the normal albumin of the blood in its true physiologic state never passes into the urine; hence, the fundamental bio-chemic conditions under which the albumin of the blood can pass into the urine depends upon a dialyzable and diffusible property, different from the normal physio-molecular structure. Therefore, whenever for any reason dialyzable albumin exists in the blood, albuminuria must follow. This may mean different conditions: First, presence of foreign bodies in the circulation or an altered condition of the proteids of the blood-plasma itself. Each of these possibili-

ties I shall consider separately and fully.

The diffusibility of soluble proteids, had been proven by many experiments. Dialyzation and diffusion correspond according to Brunton and Traube. Amongst the contributors I mention Rosenstein, Runeberg, Corvisart, Schiff, Brunton, Bernard, Patton, Landau, Graham, Barreswil, Bernhard, Thenard, Dupytren, Osborne, Hamon, Vogel, Macacci and others.

Many attempts were made to lay down certain rules for the characteristics of such proteins in circulation which transudate into the urine. Csatory undertook to find a special albumin-quotient by division of the serum-albumin from the globulin, which bears relation to the rapidity of circulation through the glomeruli.

Freund accepted a higher coagulation temperature of these albuminoids than the normal. Fox, Wright, Ross, Kreidl, Hungstenferd, and Tunis believe in deficiency of the coagulating power of the blood and recommend physiologic tests with calcium lactate. Of greater importance is it that Loeb found the Koranyi-index increased and demonstrated a decrease of the NaCl excretion with simultaneous diminution of the quantity of the urine. Of similar opinion was Fuchs.

Of special value were the many experiments of Stokvis, Brunton, Power, Ott and others. These consisted in injecting into the circulation egg-albumin, which afterwards appeared in the urine. Pichler and Vogt found that the injection of casein causes nucleo-albumin to appear in the urine.

This is simply an experimental hamatopoiesis, which in such form is of no value for us, as being the result of agents from without; for us are of importance such conditions which bring about these alterations from within.

Faulty metabolism deserves a prominent place. Gubler saw in 1854 after the ingestion of eggs, albumin in the urine. So did Brunton after giving nutritive egg enema. Such possibilities would arise accordingly every time after the ingestion of a greater amount of albuminous food than the individual can metabolize perfectly.

This may mean a too heavy meal, overeating or overfeeding, with disregard to power to assimilate and metabolize. In this sense expressed themselves: Barreswil, Bernhard, The-nard, Dupuytren, Osborne, Porter, Ham-mon, Marcacci, Brunton, Carter, Al-lard, Weber, Sejournet, Fox, Anders, Kaliski, Weigert, DaCosta, Legendre, Hare, Gray, and others.

Other factors which bring about such conditions from within besides alimen-tation are manifold. Rees was the first in 1852 to hint at such factors, fol-lowed by Zimmerman, Porter, Wood, Neubauer, Vogel, Wundt, Senator, Semmola, Begbie, Simon. Malnu-trition would belong here and was con-sidered by some as causative: Simon, Semmola, Poole and Bacquerel. Next would be anemia, in fact, Sternberg found transient albuminuria in 3 to 4 per cent of all cases of chlorosis. This was corroborated by Oswald, Schoen, Shattuck, Moxon, Frerichs, Gubler, Edlefsen, Burton and Ziegler. Moxon and Shattuck established a connection between senility and orthotic albumin-uria. Verco was of the opinion that the body-temperature in the feeble is causative and explains the disappear-ance of the albuminuria after rest by the even temperature of the bed upon a feeble organism.

Here also belongs partly the ap-pearance of albuminuria after exercise and bathing by hydration or dehydra-tion of the blood, and such changes in the blood as seen after exposure to

Roentgen rays and high frequency cur-rents, as the writer has had opportu-nity to observe. Other conditions may change the blood plasma. For exam-ple, any mechanical means which in-duce a limitation or reduction of the oxygen in the blood. Pichler, and Vogt have brought on traces of Albu-min by such means and by the tempor-ary obstruction of the femoral and re-nal arteries. Rendu found the pressure of an ovarian cyst upon the renal ves-sels to be the cause of albuminuria. Casaretti succeeded by applying bands to the limbs and inverting the position. Seeley did so by constricting the tho-rax. Johnson believes that the albu-minuria after bathing, is due to the pressure of the water when the body is immersed. Palpation has produced the same symptom. (Schreiber, Menge.)

Often albumin is found in the new-born, in fact, as far back as 1843, Prout declared this to be normal. Le-gendre claims that the delayed breath-ing after difficult labor is responsible for this by imperfect oxydation of the blood. Here I may mention that Sem-mola produced albuminuria in animals by covering their whole skin with air-tight materials. Guttman spoke of secretions which find their way into the blood. Of importance may be the in-ternal secretions, especially the sexual glands. I am inclined to consider as such the albuminurias of puberty. (Menstruation — Editorial in New York Medical Journal, July 7th, 1906.)

How is it then that we do not see the manifestations more frequently; over-eating and over-feeding and mal-nutrition being of such ordinary oc-currence, far more so that we really observe orthotic albuminuria? We have to look further. The next step would be to look into the circulation and the hemic pressure. Such a factor doubtless exists. It is known that the



urine of the new-born often contains traces of albumin. (Flensburg, Sjoquist, Dohrn, Legendre, Prout, Pollack). Aside from a possible blood change already mentioned, I quote as high an authority as Virchow who explains such albuminuria by the sudden change in the circulation at birth due to alterations in the hemic pressure with the first respirations.

Skoda was the first in 1851 to launch his theory of venous stasis. He was followed by Traube, Koerner, Stockvis, Brunton, Power, Lang, Ellis, Smith, Ralfe. Brunton and Power based their belief on venous stasis upon the fact that large doses of digitalis made the experimental albumin disappear. The question of high and low pressure was discussed by many: Landau, Loeb, Smith, Ralfe, Craig, Wiley. Patton, Douglas and McKenzie accepted high and low pressure.

High arterial tension increases the serum-albumins and low arterial tension the globulins. Wright, Ross, and Fox believe in a diminished hydrostatic pressure in the renal capillaries.

Senator said that by standing, the venous pressure is increased and the arterial pressure decreased. This contradicts Runeberg's statement that the animal membranes are more permeable under low than under high pressure. Edel claims a paradox when he says that such influences which increase the blood pressure in the healthy, lower same in the orthotic. I refer to the articles of Landau (Osmotic pressure), Senator (Porosity of renal capillaries), Loeb (Insufficiency of renal vessels), Erlanger, Edlefsen, Lecorche, Talamon, and others.

Another condition in which we find albuminuria is a period of life when the circulation is often faulty, and in fact by looking over the literature, I find that orthotic albuminuria manifests

itself most frequently amongst children. As early writers as Prout, 1843, discovered this fact; followed by Kjellberg, Rayher, Dohrn, Richter, Ekkert, Archembault, Dukes, Ullman, Edwards, Heubner, Bniet, Moxon, DaCosta, Tiemann, Fox, Schiff, Jones, Symonds, Chapin, Kelly, and others.

Moxon is responsible for the term of "Albuminuria adolescentium". Reyher claims that in such children the heart is found smaller than normal and therefore the circulation uneven.

Schiffer believes that the heart in such cases is not sufficiently adopted to the demands of beginning puberty. The occurrence is extremely frequent. Ullmann found it in 14 out of 42 girls below 13 years of age. Edwards reports numerous cases from Southern California.

Another condition under which circulation is heavily taxed and at the same time the Koranyi-index becomes altered, is exercise, and this influence has been recognized by the following: Koerner, Leube, Hamon, Edlefsen, Dukes, Smoler, Brunton, Johnson, Jackson, Coley, Anders, Boston, DaCosta, Richardson, Finot, Capitan, Chateaubourg, Hwass, Vanderpoel, Simon, Allard, Weber, Wood, Dunhill, Patterson, Huger, Mueller, Shepherd, and others.

Koerner was the first to connect in 1860 fatigue and the albuminuria of the soldiers. Hamon in 1861 found the amount of albumin to be in proportion to the amount of exercise. But the great teacher Von Leube opened the new era of our understanding of this manifestation when in 1877, he systematically examined the urine of the soldiers of the garrison at Erlangen. He found albumin in 4 per cent of all soldiers examined, and in 16 per cent after prolonged marches. Later writers attributed bicycling, racing,

football and swimming. Yet, as plausible as the theory of hemic pressure may appear, I must ask with Kraus: Why are not all cases of aortic insufficiency showing albumin in the urine?

Furthermore, we have experimental proof that hemic pressure alone cannot be causative. Seelig explained the success of his experiments at first by increased blood pressure, but the cartoids failed in later experiments to register rise of pressure and on section he found the renal cortex not congested but anemic, and the albuminous granules in the glomeruli were within the physiologic limit. Besides this, the injections of soluble albuminoids in the experiments of Runeberg failed to register rise in pressure; indeed the permeability was greater under low pressure than high pressure.

The next theory we have to consider is the neurophathic origin. Hamon proposed in 1861 the term "Albuminurric neurosis" due to a toxic irritation of the vagus. Arthaud and Butte attempted to establish a hypothesis of morbid physiology of the pneumogastric nerve in relation to the membranes and viscera supplied by it.

Vanni demonstrated that experimental neuritis of the vagus was followed by albuminuria. He with Butte and Arthaud demonstrated that excitation of the pneumogastric produced diminution of the elimination of water. Freichs gives as cause a toxic irritation of the fourth ventricle above the glycosuric area.

Bennett, Gray, Raymonds and many others gave contributions about the connection of albuminuria with mental disease. Fere saw it in two imbeciles after fits of anger; Voisin and Peron after epileptic attacks. Lantos believes in reflex-excitation of the vasomotor nerves of the renal circulation. Carter found albumin after prolonged

anxiety. Fuerbringer described a case where albumin appeared after every nervous depression. Corlieu called it a idiopathic neurosis.

Filipowitch found albumin after emotions, but never in the morning. Weidenfeld refused to recognize any but the neuropathic causation. Gray and Wood found albumin often in the neurasthenic and neurotic. Such nervous causation lead Quain, Lucas, Fox and others to explain the albuminuria of adolescence and puberty by masturbation so frequent at that age, but were contradicted strongly by Duke and Sterling.

The neuropathic origin I found further mentioned by Dukes, Huppert, Kelly, Chapin, Symonds, Lancereau, Finot, Capitan, Spiegler, Goodhart, Bertrand, Long, Chateaubourg, and others.

That neurotic condition may be a factor, is substantiated by the fact that neurotic conditions can be inherited and actually there is reason to believe in an inherited predisposition for the orthotic albuminuria. Such cases were reported first by Dickerson in 1888 and corroborated by Senator, Lucas and others. Lacour, Heubner, Schoen, and others found several cases in one family. Dickinson even in at least four generations.

Both exercise and neuropathic influence may lead to the same consequence; that of forming fatigue toxines and exhaustion material, both of which are albuminous bodies. Febrile conditions, such where there is wasting of tissue, must have the same result.

Deubler brought out a causative connection between the splitting up of proteids during antipyresis. Many similar observations were made so by Schnaase after vaccination. Same origin was given by Simon, Gubler, Gerhardt, Weber, Uri, Wesener, Germain, See

Hare, Bagdanoff, Mabboux, Lilienthal, Praetorius, McConnell.

These cases properly do not belong here, no more than the proteuria of suppuration, puerperium or resorption; as in fact any hematopoiesis may be causative, but beyond physiologic limit.

Last I must mention the connection between albuminuria and tuberculosis. As early as 1852, Beneke feared that the presence of albuminuria without pathologic signs may mean tuberculosis.

Similar opinions had Becquerel, Gubler, Skoda, and others. Bruhl, Schroder and McConnell contributed to our knowledge of albumoses in tuberculosis.

It is the later opinion of many like Mery, Heubner, Reyher that orthotic albuminuria in the young is to be considered a pre-tubercular manifestation.

In relation with tuberculosis I must mention a proteinuria of later protein derivatives which give the azo and diazo reactions by the Ehrlich and Giesler test and the modifications by Burghardt, Michaelis, Bondi, etc. They all consist in the use of sulphanilic acid or paramidoacetophenon.

By a more or less so far unknown process, oxyproteic substances (according to Spath, Bodzinsky, Gottlieb and Cloetta), most likely sulfodiazobenzols give the well known colors and sediments, which both by Becker, Lowinson, Ehrlich, Michaelis were considered of prognostic value. It may be of interest to mention that Williams discovered lately that the African race does not respond to this test.

It is hardly within the scope of this paper to discuss the fact that Frankel found the differentiation between caseous and croupous pneumonia possible by this reaction. DeGrazia and Petzl claimed it to be a sign of mixed infection in tuberculosis. Opinions differ as

to the prognostic value. Some found it to be of such unfavorable significance that the positive reaction excluded the sufferer from sanatoria. It is found to be a serious prognostication by Michaelis, Damen, Lowinson, Wood, Upson, Holmgren, and Williams. Wildstrand went so far as to consider even only one positive reaction as serious. Burhardt and Clemens and Von Ruck consider it not always of bad prognostic value; while Babcock mentions the fact that the reaction is often absent in advanced cases even with formation of large cavities.

On the other hand Petri, Penzold, Becker and Badden consider it of no prognostic importance; and the researches made in Vierordt's Clinic by Junker, seem to prove its relative unimportance.

Having considered separately the different causative factors, we come to the conclusion that they all have a certain relationship amongst themselves and depend partly upon each other. We are not before such a puzzle as it seemed at first; at any rate we are absolutely justified in rejecting the extreme views of Millard and Osler; and accepting the fact that proteinuria can occur within the normal functions of the kidneys and within the general construction of the term "good health". If we find proteinuria in the sick, we have to assure ourselves if we can exclude, first, organic lesions in the kidneys by absence of organized deposit. This is of the greatest importance with our tubercular patients.

Walsh reported at last year's National Congress on Tuberculosis that he found in cases of pulmonary tuberculosis, albumin in the urine, by heat and acetic acid, in forty-seven per cent. of all cases. He gives the autopsy reports of the Henry Phipps Institute, the Philadelphia Hospital, The Penn-



sylvania Hospital and his private practice, of these fully 55 per cent. showed tubercular nephritis in some form. Therefore, albumin in the urine of the tubercular, which is of large molecular structure, is of grave pathognomonic importance.

In the case of a febrile anemic or marantic condition, we must observe the amount of exercise taken, because under these circumstances, merely getting up may mean as much as a prolonged march for the healthy; and it cannot be our desire to overtax such a person.

It is well to remember the emotional case of Filipowitch, in which, after night's rest, the urine was free; and take into consideration the anxiety, worry and homesickness which aggravates so often our tubercular patients, especially when the surroundings were not congenial.

We furthermore have to direct our attention to the diet, especially when we attempt to build up tissue, as is frequently empiric in the treatment of tuberculosis. The indiscriminate forced feeding with raw eggs and other proteins may be the source of filling the circulation with waste products, of which the proteinuria will be an indicator, and which in course of time must be followed by metabolic disturbance, which in turn will reflect upon the general condition by lowering the recuperative value of the blood plasma.

Then again, if we have to deal with an infiltrated organ, we will discover the proteoses of smaller molecular structure, the so-called polipeptides of Fischer, which give partly the buiret colors as soon as recession of the infiltration begins. On the other hand, the presence of the finer bodies, of which we know so little and the presence of which we discover only by the diazo reaction, will show the presence of later

protein derivatives and often a serious septic condition which only in rare cases cannot be demonstrated otherwise.

Again, if we find no causative factor like exercise, faulty diet, or organic disorder, we ought to look for a diathetic condition which may alter the physio-chemic structure of the protein-molecular in circulation; be it uric acid, oxalic acid or chlorin or what Senator calls "a predisposition" or Leube, "an abnormal porosity to proteins."

In conclusion: In regard to orthotic albuminuria we are unable to give any chemical test an exclusive significance. Our chemic means so far are too limited. Orthotic albuminuria is of apparently obscure hematogenetic or functional origin of various natures. Therefore, every case has to be considered individually and treated accordingly. Orthotic proteinuria merits our attention only as a manifestation, not as a disease.

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## SCARLATINAL SORE THROAT.\*

(By Dr. Troy C. Sexton, Las Cruces.)

Inasmuch as we have had all over the Territory more or less sore throat of a scarlatinal nature, and in some places assuming the proportions of an epidemic, I have decided to bring the matter before the Medical Association, especially since there are so many cases of so-called sore throat, that are not receiving any attention. This is a serious matter, as we have experienced here in Dona Ana County during the past few months. I bring it up not with the idea of introducing anything new, but merely to elicit such discussion as will be of benefit to ourselves and protective in its nature, to the public health.

The sore throat, or the anginal form of scarlatina, is about as protean in type as is the classic description of the general infection. It can be seen in all degrees of severity, from a simple redness of the pillars of the fauces, and tonsils; to an edematous, ulcerated abscessed or gangrenous condition of both tonsils, and the uvula. The simpler forms are very mild, and not associated with other than local symptoms of an inflammatory nature. Constitutional symptoms embracing fever, aching, rapid hard pulse, and eruption, associated with inflamed, or infiltrated lymphatic glands of the cervical region, are lacking. These throats are undoubtedly infectious, but just to what extent, it is difficult to say. They are dangerous to the community, there is no question. There are cases that are so mild that they do not see a physician, thinking all the time that it is no more than a sore throat from an exposure, which every one can recall of having experienced. These are the cases that do so much to keep the disease endemic, and make it very hard

to control. And just as long as they are not brought before the attention of the men who have the charge of protecting the public health, and of preventing any and all infringements upon the rights of the public, both before the infection is established, and the focus is found, we will have the disease ever present, and be unable to eradicate it. In those cases where the diagnosis is clear, and the patient is so ill as to be placed in bed, there is decidedly less danger to the public health than in the milder ones, because then we can use scientific methods to combat the spread of the infection. We are at the mercy of the infection, in the milder cases, where the patients are walking about, because we have no knowledge of its existence. "Forewarned is forearmed", and if we do not know of the presence of the infection, we cannot avoid it. If we do not know where to strike we cannot overcome the enemy.

Taking a retrospective view of events after the battle is fought we can then coolly and collectively look over our cases, and learn much that will be of benefit in after days, the fruits of experience. Previous to the recent epidemic that we have just passed through, certain cases arose which we were not certain of, but the aftermath reveals the nature of the infection that we were having. Some of the cases were so very mild that we only entertained a suspicion of something indefinite, but when one case, or maybe two reported with a well defined albuminuria, there was something certain. Until this time, there were practically no cases, in those of that immediate time, that had an eruption. One case in particular, was very interesting,

\*Read before New Mexico Medical Society at 26th Annual Meeting, Las Cruces.



coming as it did in the van of the epidemic. It was of a young man who had a predisposition to acute tonsillitis. He had a typical attack in every way, resulting in a tonsillar abscess. There was no rash, strawberry or raspberry tongue; no rapid hard pulse, as is usually characteristic of scarlatina. He was depressed and quite sick for a day or two, but as soon as the abscess evacuated, he improved rapidly. He had no sequellae leading me to suspect that he had a scarlatina. In a few days a similar case developed, but with a longer duration, a sharper attack and an identical throat, and it was so swollen as to prevent swallowing. The picture was that of a quinsy or abscessed tonsil. This case did not lead me to think that he had scarlatina, because the picture was so distinct. The outcome was the same as the one above mentioned, yet a bit slower in recovering. There was never any rash, but only a slight delirium at night, and some restlessness. There was nothing indicative in the pulse and he did not present a post-scarlatinal albuminuria. However, I might say just here, that several of the students who were with him at nights developed a transient sore throat, but nothing more. As there were other cases of this same sore throat in the school at the same time, I cannot say definitely that they developed it from this case. On the contrary it cannot be said with positiveness that they were not infected from this one. I firmly believe if he had a scarlatinal infection, it was a double infection, as I am sure of the tonsillitis.

In the outbreak that we have had, the anginal form was far in excess of the more typical cases, those presenting an eruption. We had many cases of this type, but innumerable ones of sore throat with absolutely no other symptoms. Occasionally, we found in cer-

tain families, an inability to speak, because of a hoarseness. One person would develop it in a family, and it would strike several before it ended. This was practically the only symptom that indicated a possibility of it being infectious in nature.

Some throats were so mildly infected, that they only complained of some pain on swallowing, objectively there was some redness around the arch and pillars of the fauces. There was very little swelling and no lymphatic involvement. From this type then, we had them in all grades of severity to the sloughing and ulcerated throats and tonsils. There was found though a condition, that was not clear to me. In the four cases there was a condition of tonsilar hypertrophy. These organs extended prominently into the throat, were not inflammatory in character after primary inflammation had subsided, but looked rather transparent and edematous. Upon inquiring of the patients in two cases, and the parents in the other two, I received a negative reply as to the existence of this condition previously to the infection. I have been undecided if the scarlatinal infection could produce this condition, but I am of the opinion that the hypertrophied condition was present before receiving the scarlatinal infection. As I did not see any of them previously, I cannot say, with other than that of hypothetic value, as to this condition, and not upon the basis of facts.

In the fatal cases that I saw, each throat was at first very red and angry, later developing a white or creamy membrane, which sloughed, and left a dirty and ugly ulcer, and to an extent gangreous. Very few of the less severe cases had an ulcerated throat, and it might be asked just here if the extreme, or ulcerated condition was a part, or a reflected picture of the physi-

cal condition, indicating a lessened resistance. Or an increased virulence of the infection. Or is it through these ulcerations that the absorption is carried on to the extent of overwhelming the patient. On the other hand, is it due to the combination of these conditions?

In the dormitory, where the young ladies were under quarantine, I made it a point to examine every throat and found only three normal throats, but I am not prepared to say that the redness was not due to an irritation of the mucosa by the formaldehyde used in the disinfection; or if it was due to the effects of the scarlatinal infection which had been prevalent. The examination was made after the formaldehyde was used, and not before, so that which might have been of value to us, was to an extent, lost. I can venture this much however, not one other case developed in the dormitory, nor from it, so far as we have been able to learn definitely, and we have been on the alert for them, and from this it might be said, or rather induced, that they were not infectious.

In these cases then, we have much to consider, and many phases to look into. In the first place, how many of these mild cases can and should be diagnosed as scarlatina? Of course when there is an epidemic, or even a few cases, before it has assumed the proportion of an epidemic, we should follow Thomas' precept—"Even an angina that occurs during a scarlatinal epidemic is suspicious." Upon looking into the literature dealing with the subject, I have found some material that carries some weight with it. Quoting from Nothnagel we find this remark,—“Without question, according to the unanimous opinion of the profession, people who suffer merely from an angina, and have no exanthem, can transmit scar-

latina.” Now, this is a direct statement, and in our place here it has borne out the truth of the remark, but are all sore throats at this time infectious, or in simpler more concise words, are they all scarlatinal? Going a little further with the same author, we find this thought, quoted from Murchison: “It is well known that when adults, who years before have had scarlatina, come into close contact with scarlatina patients they easily contract angina, with little or no fever, and no eruption. I have frequently found that when one or two children in a house have had scarlatina, every adult in the same dwelling has suffered from a severe angina.” “Now, such an angina is a scarlatina in a modified form,—called scarlatina facium or scarlatina latens by certain authors,—and it is probable that those who are attacked in this way can transmit the severe forms of the disease.”

According to Johannessen, quoted in the same book, the foregoing statements are practically corroborated. His words are, viz: “Attention is called to the fact that scarlatina can appear merely as a simple angina, especially in the case of adults and grown children. There exists a whole line of such reports,—(etc.)—and often there is the distinct statement that such cases (angina scarlarinosa, etc.), just as the more pronounced forms, have carried the infectious substances with them.” Forchheimer, in the 20th Century Practice of Medicine, has this to say: “—any of the other members of the family show evidences of throat affection, they should be kept under supervision until a positive diagnosis of the nature of the throat trouble can be made. In such cases it is necessary to remember that scarlatina without the eruption is just as dangerous as regards the spread of the disease, as scar-

latina with the eruption." After the passing of the premonitory symptoms of the scarlatinal onset, the "throat presents the first demonstrable lesions. They are always present, and gets progressively worse for two or three days," according to Somerest. He declares that they may be very slight, amounting to a slight change of color of the mucous membrane of the throat which persists, and extends up to the time of the appearance of the eruption, if there is any. The throat lesions begin as a tonsilitis, rapidly becoming a pharyngitis, and in a few hours, follicular deposits and much swelling may be seen. The progress of the inflammation along the fauces and palate, is specified as forming a distinct margin, as is the case in erysipelas, but this has not been my observation in the cases that I have attended. He also describes pin point visicles existing upon the palatal mucous membrane, corresponding to the punctata appearance of the skin. I have not made a close enough observation to make any statement concerning this portion of his remarks. He states, too, that attendants upon scarlatinal patients are often attacked with inflamed and sometimes intensely painful throats, but that these produce no complications, other than is usually incident to non-scarlatinal sore throat, and not followed by any desquamation. Dr. Somerset's statement that "Just as the throat lesions and temperature constitute a *sine qua non*, so the subsequent skin eruption is a necessity before a positive diagnosis is possible" I cannot entirely agree with, because we do have cases of scarlatina without the eruption, and if we fail to diagnose a scarlatinal sore throat because we have no eruption then we are making a grave error, and we would not control the infection in ages. I do not say that in some cases that it is

very difficult to make a diagnosis, and in some cases it is absolutely impossible, since we have no laboratory proof that we can resort to as a last measure. They are so mild, without even a fever, and signifying nothing more than a sore throat, from which another may become infected in a little while after exposure. The tongue may not be affected excepting to indicate a febrile condition.

Are we justified in making a diagnosis of scarlatinal angina if we have a redness alone of the mucosa of the tonsils, pharynx and palate, provided we have no lymphatic enlargement, no prominent papillae of the tongue, or with the more characteristic appearance of this organ? I believe that we should have more than the presence of the epidemic to declare an apparently simple sore throat as infectious! The tongue, however, cannot be relied upon to furnish the corroborative evidence, as I have seen the prominent papillae present in cases without the sore throat, and *vice versa*. According to Schamberg who examined 100 cases of scarlatina with reference to the lymphatic glands, found that the inguinal were enlarged in 100 per cent of the cases; the axillary in 96 per cent. of the cases; maxillary in 95 per cent.; post cervical, 77 per cent.; anterior cervical in 44 per cent.; submaxillary 36 per cent.; epitrochlear in 26 per cent and the sublingual in 25 per cent. He claims that it is a valuable diagnostic feature in differentiating between diphtheria and scarlatina. Of course, certain expectations must be made in this, as a syphilitic and, in many tubercular cases, the glands might be misleading.

We do not know the specific agent or poison producing scarlatina, so we have only our mature and better judgment to follow in these cases.

The throat, as has been said before,



usually presents the first demonstrable lesions, and we should pay especial attention to it in the presence of scarlatina in the community. It plays a very prominent part in the history of the disease. Dowson (1893) tried to establish the fact that the first and essential lesion of the disease was to be found in the throat, just as a chancre is the primary and essential lesion of syphilis. For awhile the French authors favored this opinion, but they would not give up the infectiousness of the skin, and admit that the throat was the primary seat of the poison.

Forchheimer declares that the "method of introduction into the system, is by means of the throat", but also says that there are other methods, as the open wounds, in labor cases, and through the respiratory and digestive tracts. Taking this view of things he reasons that the location of the poison is as follows: "It stands to reason that the first place it would be sought for would be those in which would be found anatomical manifestations," and such, he declares, as a matter of fact, has been the case. At first it was the skin principally that was held accountable for the spread of scarlatina, but latterly the skin is being disregarded as a source of infection and must be made of the throat.

We get further evidence that the throat is the center that receives the poison, reasoning by analogy, since we know that in case of infection of an open wound, the first place that the infection is evidenced by anatomical lesions, is the site of the wound. If this is the case then we should naturally expect that the first place to show the evidence, to be the first place to receive it, and in this case it happens to be the throat. This does not declare, however, that the only and sole area of the infection is in the throat, but as it is in-

fectious, as all authorities agree, then it should be watched. From the literature we glean the fact that the throat is considered infectious unanimously, but not that it is the only infectious lesion in the disease. We cannot prove this, because we do not know the specific cause of the disease, and cannot make the assertion positive for the lack of laboratory evidence. If it is, then we can and should marshal our defense against the throat, and there make our fight. If it is true, with our present quarantine regulations, we can not hope to cope with the infection very successfully, because we cannot force the public to accept a quarantine, or to submit to one, for an apparently simple sore throat, where it is so hard to accept one for the more severe conditions. On the other hand, if we allow them to go about with it, they will expose every one that they come in contact with.

If the throat is the point of infection, it will explain the endemic existence in the larger cities. It will to an extent explain the apparent progression of the disease with little regard to quarantine, especially in certain epidemics. How? Merely from the fact that so many walking cases are in every epidemic, who, deeming that they have a mild pharyngitis, pay no attention to it, or seek medical aid, and as a consequence spread it to the four winds. Especially is this the case in a laboring or poor class of people, who from neglect or poverty, cannot afford to have every little illness investigated and treated. As a consequence we will not be rid of the disease until we have exhausted the infectible supply.

Granting that the sore throat is infectious, it must remain so for awhile. How long should it remain under observation before releasing it from quarantine? I have found this as difficult

question to determine as the diagnosis, in the mild cases, and even yet I am not sure as to the time of releasing them. Here again comes the disadvantage of not knowing the specific organism, that we might make periodic observations with the microscope, and in this way find when the area is free of infection. This is impossible with our present knowledge of the disease. The discreet thing to do is to wait till the throat is normal in every particular. It is not safe to take anything for granted, where the public health is at stake, and it is only safe to make an error on the right side, if one must be made. Just in relation to this, it might very appropriately be asked if it is necessary to carry the disinfection to the same degree as in the more severe cases? It is true that the throats are infectious, but are they as much so as the desquamation of the entire cataneous surface? The throat does not last so long, is not so extensive, and there is comparatively little secretion from the throat. I hope that in the discussion this point will be freely dealt with, because it is just here, that we may hope for the most success in the management of the disease, along with quarantine.

Conclusions. In an epidemic of scarlatina, all anginas should be suspected, and receive special attention. That the angina is a form of scarlatina, and is prevalent in all epidemics. That it can transmit the scarlatinal infection, and even the severe forms of the disease. It seems to attack the attendants upon the scarlatinal cases, and principally the grown children, and adults, and those who have had the disease in earlier life.

#### Bibliography.

New York Medical Journal, November 17, 1906. Somerset.

Nothnagel's Encyclopedia of Practical Medicine. Scarlatina.

Twentieth Century Practice of Medicine. Scarlatina. Forcheimer.

#### DIAGNOSIS.

"How was it Dr. Knowit got such a big fee from Talkative?"

"Because when he was called to attend Mrs. Talkative for a slight nervous trouble he told her she had an acute attack of inflammatory verbosity."

"Well?"

"And recommended absolute quiet as the only means of averting paroxysms of *cacaothes loquendi*. She's scared dumb."—*Baltimore American*.

#### A PET NAME.

Miss Meadowsweet—Excuse my ignorance, but ought I to call you Mr. Squills or Dr. Squills?

The Doctor (irascibly)—Oh, call me anything you like. Some of my friends call me an old idiot."

Miss Meadowsweet—Ah! but those are only people who know you intimately.—*Stray Stories*.

THE EXAGGERATED EGO has been defined by an eminent alienist as "a disproportionate idea of importance of self, a belief that one is clothed with powers, capacity and ability far above normal or above those actually possessed." Rather a roundabout description, this, of a swelled head.—*N. Y. Med. Times*.

Vicar's Daughter—I hear that you son is ill, Mr. Hodge?

Farmer Hodge—Yes, miss. He's got what they call appindercitis—but you know it was a needle he swallowed.—*Ally Sloper's Half Holiday*.

# PRIMARY TUBERCULOSIS OF CAECUM AND APPENDIX. REPORT OF CASE.\*

(By B. F. Stevens, M. D., El Paso, Texas.)

Miss M., aged 24. No tubercular history of any kind in family.

## Previous History.

Had always been well until age of 14; menses appeared at age of 13. At that time she developed what appeared to be an attack of appendicitis. Acute severe pain in right side, low down, with elevation of temperature and vomiting. This was followed by recovery in two weeks. She then had two such attacks a year until age of 17, when they occurred more frequently, coming on without apparent cause about every two months.

Various diagnoses were made, as female trouble and indigestion. She was drugged and poulticed during each attack until it subsided.

During the past two years, she has noticed a tumor in right inguinal region, larger during the attacks, but always present. Ingestion of meat or vegetables during this period caused vomiting and colic, so patient has practically been on liquid diet.

## Status Praesens.

Patient weighs about 70 pounds: is thin and anaemic; has been acutely ill two weeks; is unable to retain anything on stomach; temperature  $100\frac{1}{2}$  F., pulse 120 to 130; Leucocyte 1 count 10,000, haemoglobin 65 per cent; urine negative.

## Physical Examination.

Chest negative; no cough or expectoration; palpation of abdomen reveals tumor in right inguinal region size of small lemon, very tender but hard. Patient was put on rectal feeding for three days, until vomiting ceased; then was fed on raw eggs, milk and beef juice for five days, and then operated on after usual preparation.

## Operation.

Operation disclosed a fixed hard tumor attached firmly to right iliac fossa, involving head of caecum. The mass was thought to be malignant so was excised in toto, necessitating resection of 18 C. of caecum. End to end anastomosis was made with a Murphy button, reinforced with Lembert stitches of silk. Wound was closed in usual manner with a gauze drain. A rubber tube was substituted the third day, when a foecal fistula was noted. I think this was caused by the gauze. The fistula closed in ten days. The button did not pass until the 56th day, though it caused no disturbance, patient being on a solid diet after the first week. She doubled her weight in three months, and was apparently well, and able to eat anything.

## Examination of Tumor.

In fresh state it was 12 C. long by 10 C. in circumference. The intestinal wall was thickened and indurated, and had lost its identity. The ileo-caecal opening would barely admit a match. The appendix was entirely obliterated in the inflammatory mass. Microscopic examination showed no trace of normal intestinal structure. Intense infiltration of round cells could everywhere be found, also giant cells. Specimen was not stained for tubercle bacilli.

## Post-Operative History.

Three months after operation, she noticed symmetrical enlargement of abdomen, gradually increasing in size. Abdomen suddenly became tender on right side. She developed a temperature of 102 with pulse of 120, with anorexia and vomiting. Physical examination showed enlargement of abdomen, more tender on right side, with probably some free fluid.

\*Read before New Mexico Medical Society at 26th Annual Meeting, Las Cruces.



**Second Operation.**

Through old scar allowed escape of serous bloody fluid from a previously ruptured left ovarian cyst, due to a long twisted pedicle. There was also a right ovarian cyst with a long pedicle, which allowed it to extend up under the spleen and over the left kidney. There were no adhesions and both cysts were cleanly extirpated. The wound closed without drainage after the uterus had been suspended after Kelly's method. Examination of line of union where resection of intestine was made, showed it to be clean and free from adhesions. The cysts were evidently of rapid growth, as nothing was noticed at first except a few miliary tubercles on posterior surface of the uterus.

Patient left the hospital at the end of the second week.

Two months later another tumor developed in the inguinal region the size of a lemon. The thigh became semi-flexed on abdomen. Pain was severe, requiring morphine. She was unable to walk. Temperature ranged from 99 to 101, and pulse from 100 to 120. A probable diagnosis of abscess was made. I again cut down through the old scar; found intestines matted together in a hard mass, but no free fluid or pus. Attempts to separate them were unsuccessful. After tearing several holes, I finally sewed up, leaving in drainage. An anastomosis was impossible because of the complete involvement of entire small intestine. Patient when from bad to worse until complete stenosis occurred two months later. Abdomen became tense as a drum-head, and at the suggestion of the patient, my colleague, Dr. Crouse, during my absence on my vacation, made an artificial anus. The tension was so great that the moment he opened the abdomen the intestines burst in several

places. She only lived about four hours after leaving the table.

**Recapitulation.**

This patient seemed to entirely recover after the first operation. Her weight doubled. She had no digestive disturbance of any kind. At the second operation the whole abdomen was clear of tubercles; there were no enlarged glands or adhesions. She was in good physical condition. The prognosis certainly seemed good, yet, in spite of her increased weight, the original trouble, only in a plastic form, recurred.

Originally, at the age of 14, she had evidently suffered from acute attacks of appendicitis, thus affording a good field for tubercular infection, which in all probability occurred through infected milk.

McArthur(1) reports such a case in a child of ten. Six months after onset, a laparotomy was done, but because of a general abdominal tuberculosis no anastomosis or resection was made. Change of climate, rest, suitable food and X-rays were used without relief. Abdomen was reopened in eight months, on account of total obstruction. The tubercles had disappeared, though a tumor was still present involving the head of the caecum. Lateral anastomosis was made between the ilium and sigmoid, which gave the necessary relief. Patient gained a pound a day for the first thirty days. McArthur thinks the infection was grafted on an acute appendicitis, due to tuberculous milk, which was afterwards found to have come from a herd, some of which were tuberculous. All deposits cleared up except tumor, which may have been due to the X-rays or the laparotomy. In my case the X-rays were not used, yet all nodules disappeared.

Intestinal tuberculosis occurs in two forms: Ulcerative, most frequently

seen in connection with pulmonary tuberculosis, and hypertrophic, which more often occurs as a primary disease.

Cornet(2) quoting from the experiments of Baumgarten, Wesner and Fisher, in feeding animals with tubercle bacilli, says: "This organism may find its way through normal mucosa without leaving any sign of a lesion. Here they may go on to further development and form tubercles and ulcers, and find their way along lymph channels to the mesenteric glands. This may be accomplished by mechanical means, and partly by the aid of wandering cells." He is also of the opinion that primary intestinal tuberculosis is due to eating infected food. Lesions of the mucosa facilitate invasion, hence the association with Typhoid.

Behring contends that tuberculous milk is a most important source of infection, both of intestinal and pulmonary tuberculosis. This theory would account for a tubercular infection following an ordinary pyogenic infection of the appendix, as in the cases above mentioned.

The feeding experiments of Calmette and Guérin(3) furnish important information somewhat along this line. They find that the single introduction into the stomach, by a tube, of a quantity of tubercle bacilli, will in 30 to 45 days cause the development of subpleural and peri-bronchial tubercles at apices of the lungs, with alveolar involvement later. Also the recent studies of Harbitz(4) of the distribution of tuberculous lesions in children afford many points in support of the belief that tuberculosis of the lungs and adjacent lymph nodes may result from invasion through the digestive tract.

On the other hand, twenty years ago, Arnold, Muscatello and Ponfick proved by their experiments that pulmonary

tuberculosis in animals was not caused by feeding infected food, but by inhalation of tuberculous particles. So the mode of infection is far from being settled.

Osler(5) in his last edition says: "Primary intestinal tuberculosis is very rare, occurring but once in one thousand autopsies on tubercular subjects in the Munich Pathological Institute, but according to McArthur, whose statistics are later and from varied sources, fifty per cent of all autopsies, children dying before the age of ten, have the disease, and that the point of infection is through the intestinal wall in over 21 per cent, and primary in about 5 per cent. (Lubarsh). Some authorities even go so far as to say that the majority of all cases of tubercular infection, both pulmonary and intestinal, occur through the intestinal wall. Hartman and Pillet published the first detailed account of hyperplastic caecal tuberculosis. (6).

Regarding mode of treatment Baum(7) advises resection, exclusion being reserved for the debilitated. American operators seem to prefer the latter mode of treatment, which in the light of my limited experience is easiest and most sensible.

(1) Surg. Gyn. & Obst. Aug., 1906.

(2) Cornet. 1st Ed, p. 10.

(3) Annals de Inst. Pasteur. 1905. Vol. XIX; 1906, Vol. XX.

(4) Jour. Inf. Diseases, 1905. Vol. II, p. 143.

(5) Jour. A. M. A., Edit. 11-24-06

(6) Kelly & Hurdon, p. 338.

(7) Munich Med. Wochenschrift. Vol. LIII, No. 36.

#### Nose Wash.

Fornari uses a hot spray for removing crusts in ozaena. It consists of 8 gm. sodium carbonate, 4 gm. sodium chloride, 4 gm. distilled cherry-laurel water, and 400 gm. distilled water.—*The Clinical Review*.

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Office of Dr. S. A. Knopf,  
16 West Ninety-Fifth St.,  
New York.

Aug. 1, 1907.

Editor of the Journal of the  
New Mexico Medical Ass'n,  
Albuquerque, New Mexico.

My Dear Sir:—

A few months ago, Prof. George Dock of Ann Arbor, wrote to all the leading medical journals of the United States a strong letter refuting in unmistakable terms the slanderous misinterpretation of my Washington address concerning the administration of morphine in Pulmonary Tuberculosis.

I had so hoped that this authoritative statement would put a stop to further reproductions of that dangerous lie; but in this I have been seriously mistaken. My daily mail continues to be swarmed with clippings, and letters

from earnest men and cranks in relation to the subject.

It seems as if this sensational falsehood receives constantly new stimulus by the thoughtlessness of overzealousness of physicians and laymen and the anti-tuberculosis cause is bound to suffer thereby.

The seriousness of the situation will be evident to you if you will peruse the inclosed appeal which I have issued to the American Medical Profession. I beg of you to publish it in your esteemed Journal, not for my sake, but for the sake of truth and justice and in the interest of the consumptive sufferers.

Thanking you in advance, I am,

Yours most sincerely,

S. A. KNOFF.

**AN APPEAL TO THE AMERICAN MEDICAL PROFESSION.**

(By Dr. S. A. Knopf, New York.)

On May 8th, the day following the meeting of the National Association for the Study and Prevention of Tuberculosis there appeared in the North American of Philadelphia a most sensational article by Mr. Richard J. Beamish according to which, during the discussion of Dr. Flick's report on medication, I was reported to have advised the killing of dying consumptives quickly and painlessly by heavy doses of morphine and to have admitted that it was my daily practice to do so. It was furthermore said in this article that there had been a bitter debate and that the session adjourned in confusion. These false statements were copied by nearly all the newspapers in the United States, were cabled to Europe and made the rounds in the papers and magazines of England and the whole European continent. In spite of explanations and denials I had sent to the Associated Press, in spite of a



strong letter written by Dr. George Dock the presiding officer of the meeting and sent to the leading medical journals of America, giving the true version of my remarks, the false statement has continued to be published and re-published and commented upon to the great detriment of the Anti-Tuberculosis crusade all over the world. For example; ignorant consumptives in St. Louis, who had read the sensational lie, refused the visit of the nurses sent to them by the society for the Relief and Prevention of Tuberculosis. The "St. Louis Republic" which published this news item said, "Consumptives since they read that report apparently have a dread that the visit of the nurse may mean morphine to end their suffering." It became thus necessary to issue the following statement by order of Prof. Frank Billings, President of the National Association for the Study and Prevention of Tuberculosis.

---

Office of The National Association  
for the Study and Prevention  
of Tuberculosis.  
Livingston Farrand  
Executive Secretary,  
105 East 22d St., New York.

Various daily newspapers published on May 8th, what purported to be a report of the remarks of Dr. S. A. Knopf, of New York, before the National Association for the Study and Prevention of Tuberculosis, in which he was made to say: "It is my practice and your sacred duty when you see a dying consumptive before you to give the sufferer morphine in plenty that the end may come quickly and painlessly."

No such statement was made by Dr. Knopf, but since in spite of an immediate explicit denial by the Doctor a great many newspapers in this country and Europe continue to publish the

false report as authentic news, Dr. Frank Billings, of Chicago, President of the National Association for the Study and Prevention of Tuberculosis, authorizes the following statement:

"Quite apart from the false position in which the speaker was placed and the injury done him, the publication of such a piece of sensationalism cannot fail to have a very deleterious effect upon impressionable tuberculosis patients throughout the country and may keep others from seeking needed medical aid."

The following statement made by Prof. George Dock of the University of Michigan, who presided at the meeting at which Dr. Knopf spoke, should preclude all further misunderstanding:

"I heard clearly what Dr. Knopf said. I am sure that I know what he meant, and am sure that everybody in the room must have understood what he said. His words could not possibly be converted into the meaning given in the public press. It was perfectly clear that he meant to relieve patients in the last stages. Everybody knows this prolongs life while making it very much easier for the patient."

LIVINGSTON FARRAND,  
Executive Secretary.

---

I had hoped that this statement would put a stop to all further comments on and circulation of the sensational falsehood. I am free to confess that I have longed for the time when the lie would die out for in spite of the loyalty manifested by my professional friends during these hours of trial, for which I beg them to accept my most heartfelt thanks, the ordeal had become almost unbearable.

It seems that such a lie dies hard and from time to time receives a new stimulus from the overzealousness of some physician or layman. Thus, for ex-

ample, through the courtesy of Dr. George H. Simmons, the editor of the *Journal of the American Medical Association*, I received a copy of the *Kansas City Journal* of last week, containing an editorial under the heading "*Should Doctors Kill*," from which I quote the following:

"The question whether a physician is justifiable in shortening the life of a patient suffering from some incurable disease by administering anaesthetics, was given a fresh impetus recently by the declaration of Dr. S. A. Knopf before the tuberculosis congress in Washington advising that consumptives should be given heavy doses of morphine to hasten the end. To the credit of the profession it must be said that physicians generally repudiate the idea as atrocious and a violation of medical ethics. A Chicago physician, Dr. Charles Gilbert Davis, voiced this sentiment, saying: 'A physician who would make a statement of that sort should be taken out and hanged. The profession has not gotten so low that it must commit murder just because it has not yet discovered a cure for some disease. There is nothing incurable under the sun. Just because the cure has not been discovered that does not mean that it never will.'"

In Dr. Dock's letter above referred to as well as in the statement authorized by Dr. Frank Billings the absolute falsehood of the respective newspaper report was clearly shown and it would seem that there was hardly an occasion for Dr. Davis to unburden his feelings for the benefit of the lay press.

Equally untrue was the report of the alleged "adjournment in confusion" and the "lively and bitter debate" which followed Dr. Flick's report, condemning the use of morphine and its com-

pound. In refutation of this reflection made by Mr. Beamish on a body of scientific men composed of many of the leading American physicians, who have devoted their lives to the study and prevention of tuberculosis, permit me to publish for the first time an extract from a letter which was received recently by Dr. Joseph Walsh, the Secretary of the section.

"I was present as secretary of the section at which you spoke and instead of the section breaking up in confusion as was stated in the newspapers the section closed in the perfectly regular way, and your statement as generally understood by the medical men seemed to be generally agreed with."

I beg the Medical press of the United States to copy this communication in the hope that it will help individual members of the profession to refute once for all the inconceivable proposition that any physician true to his calling could possibly propound such a doctrine as shortening the life of any patient entrusted into his care. To the individual member of the profession in this country and abroad I address a personal appeal to embrace every opportunity to disabuse any individual who may labor under the misapprehension that I or anybody else of the American Medical Profession recommended shortening the lives of consumptives or any others by the administration of chloroform, morphine or similar narcotics. I make this appeal not merely for my own sake but above all for the sake of truth and for the sake of consumptive sufferers in this and in other countries.

S. A. KNOPF.

New York, July 30, 1907.

## BOOK REVIEW.

Gaining Health in the West (Colorado, New Mexico, Arizona), Being Impressions of a Layman, Based on Seven Years' Personal Experience with "Climate", by George B. Price; \$1.00 net; published by B. W. Heusch, New York.

This little volume answers the practical questions asked by the health seeker who has been ordered West by his physician.

It treats fully of the different modes of living, compares the relative merits of life in a tent, ranch, boarding-house and sanatorium, and gives the cost of each. The author discusses the time necessary to regain health; the question of obtaining employment if one needs to work for one's living.

There is information concerning the social and ethical conditions, and those who are troubled as to whether they should go away alone or take their families with them will find the matter thoroughly discussed.

The author refrains from encroaching upon the physicians' field. Here are a few sentences taken at random, which illustrate his attitude toward the profession:

"A first-class, conscientious local physician is, therefore, your safest adviser and your first necessity." Page 19.

"The whole question as to the advisability of living in a tent would better be left until you are on the ground and have the advice of the local physician there. It is not always and everywhere advisable for every patient. While some are undoubtedly benefited by tenting, under the right conditions, all are not. Let the doctor decide it for your case." Page 60.

"Bicycle riding and horseback riding should be enjoyed only with the doctor's permission, since these forms of exercise are often too violent and may be even dangerous for those with tendency to hemorrhage. Tennis, for the same reason, must be avoided." Page 89.

"Don't neglect to live up, fully, to your doctor's advice. If you haven't confidence in him, get another; but don't try to be your own physician." Page 124.

"Don't join a gymnasium, run, swim, or

take any other exercise beyond short walks, without a doctor's advice." Page 125.

## DISEASES OF THE DIGESTIVE SYSTEM.

Edited by Frank Billings, M. D., Professor of Medicine, University of Chicago, and Professor of Medicine and Dean of Faculty, Rush Medical College. An authorized translation from "Die Deutsche Klinik" under the general editorial supervision of Julius L. Salinger, M. D. Cloth, 824 pages. With forty-five illustrations in the text. D. Appleton and Company, Publishers, New York and London.

Dr. Billings, who enjoys the highest esteem of the Profession, says in the Editor's Preface:

"Today diseases of the Digestive Tract stand in the forefront of subjects which interest the practitioner and the surgeon. Many of the diseases included in this volume lie on the borderland of medicine and surgery. This volume includes articles from many of the most eminent men of Europe, specialists in internal medicine and in diseases of the digestive tract. The subjects are treated very fully and at the same time in a concise and practical manner. The modern methods of examination, including physical and chemical measures, are clearly set forth, which will enable the practitioner to apply them with the same ease that he may make a physical examination of the chest and a chemical and microscopic urinalysis. The diagnosis of the various diseases is fully discussed and the treatment, including the dietary, is satisfactorily full and complete."

## List of Contributions.

Stenosis of the Esophagus. By Th. Rosenheim, Berlin.

The History and Clinical Indications of Gastric Lavage. By W. Fleiner, Heidelberg.

Functional Diseases of the Stomach. By H. Leo, Bonn.

The Diagnostic and Therapeutic Significance of Secretory Disturbances of the Stomach. By H. Strauss, Berlin.

Diagnosis and Treatment of Gastric Dilation. By F. Riegel, Giessen.

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The introduction treats of the importance of physical diagnosis, and the qualifications for its successful study.

Each chapter is presented in a most interesting manner, and every subject is thoroughly considered. The illustrations are excellent adding greatly to the value of the book and the index is complete.

## THE OBLIQUITY OF THE RELIGIOUS PRESS.

Samuel Hopkins Adams in Collier's, August 3rd., has surely started a panic of remonstrance against the use of the religious journals by quacks and patent medicine vendors, and moreover against the editors of religious journals for supporting the tottering Great American Fraud. The countenance of the church and the moral support granted by the writers of religious journals give the medical fraud his chief asset, for "religious backing of whatever kind, inspires confidence." Mr. Adams affirms that the only religious backing openly on the market is religious journalism. The journals need the money, and the fraud needs their defense.

Serving God in their editorial paragraphs and Mammon in their advertising columns appear to be facts which have been brought most forcibly to the attention of every religious writer in this article. Inasmuch as these two matters cannot be reconciled, it is to be hoped that our ecclesiastical brethren will in the future pay more attention to that passage in the scripture which says "you cannot serve God and Mammon."

### After the Show.

Sweet Singer — The leading man does not get so many curtain calls since he has been married.

Comedian—No; I think he gets more curtain lectures.—*Chicago News*.

### Force of Habit.

"I declare I never saw such a fellow. He is always cutting up."

"But, then, you must remember he is a medical student."—*Baltimore American*.

### BYE-BYE, BYE.

The Missouri State Board of Health, not being able to appreciate the claims of Drs. Bye and Johnson, the notorious cancer specialists, revoked their licenses to practice and is to be congratulated upon ridding the community of this pair of impostors.

"Cancer and Its Cure", a beautifully prepared pamphlet, was introduced as evidence during the trial and it developed that the "long years of study" claimed by this couple, consisted of short courses in poor schools, and that the "great work" was written in "two or three weeks" with the aid of an advertising firm.

Dr. Lutz of the Board proved that the defendant knew absolutely nothing about cancers; that he couldn't tell the difference between a cancer and a common ulcer, that he was a fake of the first water.

### A RAILROAD EQUIPMENT.

The Emergency Chests supplied to the shops on the Erie Railroad system, contain the following:

Twelve gauze roller bandages 1 inch; 6 gauze roller bandages, 2 inches; 6 gauze roller bandages, 2½ inches, and 6 gauze roller bandages, 3 inches wide; 6 Red Cross ligatures, silk and catgut, with needles threaded; 3 one yard cartons bichloride gauze; 1 spool "Z O" Adhesive plaster; 4 ounce bottle Synol soap; 4 quarter pound packages bichloride absorbent cotton; 2 two ounce jars iodoform ointment; 1 Hand Book of First Aid; 1 box Munroe's antiseptic powder; 1 Tourniquet (Esmarch's.) 1 pair bandage scissors; 1 two ounce bottle Aromatic Spirits Ammonia, with glass stopper; 3 one ounce packages suregon's lint; 6 splints, Whitwood; 1

paper safety pins, medium; 1 pint bottle carron oil for burns; 2 blankets; 1 gallon enamel basin; 1 stretcher.

### He, She and It.

Diplomatic Bachelor (*who has forgotten whether the baby is a boy or girl*)—Well, well, but he's a fine little fellow, isn't she? How old is it now? Do her teeth bother him much? I hope he gets through its second summer without getting sick. She looks like you, doesn't he? Every one says it does.—*Puck*.

"Our Dr. Wiley" is en route for France. He has been engaged by the French government to make a scientific inquiry into the charge that French wines have been grossly adulterated. If he wishes a corps of American volunteers to act as test tubes, drafting will not be necessary.—*Puck*.

### Her Remedy.

He—I understand you have been attending an ambulance class. Can you tell me what is the best thing for a broken heart?

She—Oh, yes. Bind up the broken portion with a gold band, bathe in orange blossom water, and apply plenty of raw rice. Guaranteed to be well in a month!—*Judge*.

### COULDN'T SUPPLY IT.

"I see you advertise everything for the baby?" said the man entering the child's bazaar.

"Yes; this is the place," said the floorwalker. "What do you want to get?"

"Well, what I want to get is something that will get up out of a warm bed on a cold night and walk the floor with a cross baby!"—*Yonkers Statesman*.

**PHYSICIANS GRANTED LICENSES.**

(July Session, Board of Health.)

Santa Fe, N. M., July 10.—The Territorial board of health continued in session yesterday and thirty-two physicians were admitted to practice upon the presentation of their diplomas and other credentials or passed the required examination. However, the licenses of several of the applicants will be withheld pending the furnishing of suitable references as to moral character and integrity.

The session of the board was devoted almost entirely to the examining of candidates who were either graduates of medical colleges not on the accredited list or have not previously been practitioners. Licenses were issued almost immediately to those admitted to practice. At 3 o'clock yesterday afternoon the board adjourned to meet again on Monday, October 14.

Practically all of the physicians who were granted licenses are recent arrivals in New Mexico and with few exceptions they have been engaged in active practice at their former locations. The addresses given are where they are now located or intend locating.

Following is a list of the physicians to whom licenses were granted:

Dr. John G. Martin, Romero; Dr. Thomas C. Rivers, Montoya; Dr. Henry T. Bailey, Texico; Dr. William L. Shelton, Montoya; Dr. William G. Bassett, Des Moines; Dr. William H. Halley, Folsom; Dr. George W. Bennett, McIntosh; Dr. J. Foster Scott, Jr., Texico; Dr. H. L. Hendricks, Dexter; Dr. Alexander F. Brown, Taiban; Dr. Dudley D. Stetson, Park View; Dr. John W. Hale, Grady; Dr. Lee V. Williams, Fierro; Dr. William E. Provines, Santa Fe; Dr. Samuel L. Wilkinson, Belen; Dr. William H. Crisp,

Farmington; Dr. William M. Guernsey, Hachita; Dr. Frank R. Porter, Santa Fe; Dr. Frank E. Tull, Albuquerque; Dr. Stephen J. King, Santa Fe; Dr. William W. Parks, Gallup; Dr. William G. Drake, Quay; Dr. G. L. Tinker, Albuquerque; Dr. Joseph H. Loving, Lloyd; Dr. LeRoy P. Strayhorn, La Grande; Dr. J. E. Manney, Tucumcari; Dr. J. F. Renegar, Leopold; Dr. John E. Bonar, Rincon; Dr. Charles A. Frank, Albuquerque; Dr. H. E. Kirschner, Albuquerque; Dr. Thomas L. Cellum, Orogrande; Dr. S. G. Sewell, Albuquerque.

**SPRING IN THE COUNTRY.**

Mrs. Dosem—Now, Willy, don't git rambunkshus! Your Paw give this medicine t' old Dobbin and the yearling bull yestidy an' they never made no fuss whatever!—*Puck*.

**Didn't Know.**

Hostess—Let's have a game of bridge. You play, don't you, Miss Greenley?

Miss Greenley—Well, really, I don't know. You see, I've never tried.—*Cleveland Plain Dealer*.

**THE USE OF ADRENALIN DURING ETHER ANESTHESIA.**

(By Charles S. Venable, M. D., Charlottesville, Va. From the Virginia Medical Semi-Monthly, February 22, 1907.)

Recognizing that my experience in the use of Adrenalin during ether anesthesia is but very limited, covering a course of only eighteen cases, and knowing the many fallacies attendant upon too early conclusions, I feel a great hesitancy in making this report. However, owing to the uniform result that has attended its use, I am prompted to do so now.

I found that 25 per cent. aqueous so-



lution of the standard 1 in 1000 gave the best results, and that by first pouring ether in the towel cone and spraying the Adrenalin solution on it, depending on the ether to vaporize it sufficiently for inhalation, was the best mode of administration. Three to six minute intervals are sufficient for its use and a total of from one-half to one ounce of this solution is enough for an operation lasting from thirty minutes to an hour. The effects are a more uniform etherization, the pulse becoming steadier, slower and of better character more rapidly than under ether alone; respirations are quiet and regular, the bronchial secretions are practically checked, and the progress of the operation is not interrupted.

These cases were not selected, and amongst them were old alcoholics; two women over sixty, one of them nearly eighty years of age. Three were very long, tedious operations, lasting over two hours, and in none of the series was an stimulation required during the anesthesia.

Recovery from the anesthetic was uniformly good; there was practically no post-operative shock, and no stimulation was needed in any one of the cases; only two patients vomited at all and very little nausea was complained of.

From the foregoing facts I conclude that owing to the contraction of the smaller vessels the bronchial glands secrete less mucus, and there is better aeration in the bronchioles and pulmonary vesicles, less ether is required to produce anesthesia and there is less probability of ether pneumonia following. The Adrenalin, acting generally from absorption, is a powerful stimulant; it materially lessens shock, lessens the capillary ooze at the field of operation, and is of great benefit to the much weakened patient.

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## CONTENTS

Editorial . . . . .	1
Some Interesting Cases of Tumor of the Thyroid . . . . .	4
The Serum Treatment of Pericardial Effusion . . . . .	10
Heart Block at Ninety-One . . . . .	12
To the Members of the New Mexico Medical Society . . . . .	14
Eucalyptus Oil—Its Therapeutic Value . . . . .	15
Cases Showing Necessity of Care in Giving Instructions to Patients . . . . .	16
Physicians' Licenses Issued . . . . .	18
Excision of the Ankle . . . . .	19
Miscellany . . . . .	20

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**EDITORIAL**

A movement has been originated by the Colorado Medical Society looking to the formation of a Rocky Mountain branch of the American Medical Association. At its recent meeting a report of the committee appointed at a previous meeting to investigate the subject reported that they found little disposition to form this branch association in the near future and recommended the subjoined as ways of bringing these societies into closer touch:

1. The appointment of, each year, by the president, at his convenience, two or more members to visit each of the following state societies: Utah Wyoming, Montana and New Mexico; and the invitation of such visitors from these societies.

2. That the Publication Committee be instructed to endeavor to secure in each of the states in question correspondents who will keep members of this society informed as to the doings of their respective societies through the columns of Colorado Medicine, and to invite from such state societies co-operation, or that they combine with this society to conduct a medical journal that should be the organ of the profession of the whole Rocky Mountain region.

3. That when questions arise of important interest to the profession of the Rocky Mountain states, the delegates to the American Medical Association from any of these states be empowered to call a meeting at the time and place for meeting of the American Medical Association, of all members from these states in attendance upon the American Medical Association, for the discussion of such questions.

So far as the writer can see from the published reports of the meeting no definite action was taken by the Colorado Society on the above recommendations other than a suggestion that for the present it would appear that it would be better to direct all efforts to the making of existing societies more effective rather than multiplying their number.

Here in our territory there is much room for improvement in our own Territorial organization and it is the earnest hope of the officers that there will be a large addition to the membership of the New Mexico Medical Society at its next annual meeting.

/—/

To the Reeling Pedestrian—"My friend, have you vertigo?"

"No; only a square and a half to go."

# **SOME INTERESTING CASES OF TUMOR OF THE THYROID.\***

(By Dr. Geo. C. Bryan, Alamogordo.)

## **Case I.**

An Albanian laborer, apparently about 40 years of age, was brought to the hospital in a profoundly septic condition. From his companions, who were fairly intelligent, I elicited the following history: He had been their playmate in boyhood and companion and neighbor in later life. He had always been well and strong. Had married young, had several healthy children, and was temperate in his habits. Since early boyhood had had a swelling on the right side of the neck, which, however, had not seemed to increase much in size and had caused him no discomfort. Three years before he had come to this country with his friends. They found work in the western states and later in the railroad camps of Colorado and New Mexico. Two weeks before he had caught a slight cold. This disappeared in a few days, but about a week after this the neck began to swell rapidly and grow painful. The swelling on the right side did not give as much trouble as other parts of the neck. He had been started for the hospital in a wagon, but was much delayed in reaching the railroad. At times it became so difficult for him to breathe that they were compelled to raise him up and fan him. Stopped several times, thinking he was dying. On examination he was found to be a man of large frame and evident previous good health and development. He was now much emaciated and presented a peculiar puffed, pallid yellow appearance of the skin. The front of the neck was immensely swollen and decidedly more prominent in the thyroid region, more so on the left side. The whole region fluctuated on percussion and the skin was oede-

matous and pitted on pressure. Was in semi-comatose condition and could be aroused with difficulty. Pulse could not be counted accurately on account of its irregularity and rapidity. Temperature 105 degrees. All other organs, except the heart, normal. Lungs perfectly clear throughout. Heart apparently hypertrophied. Was given large stimulative enemata and pulse improved somewhat. Was placed on table at once and, without anesthetic, neck opened from chin to supra sternal notch. Numerous small lateral incisions were made also, and the tissues thoroughly curetted and washed out with mild bichloride solution. Much necrosed matter and a great deal of pus came away. Necrotic areas found everywhere. Muscles in many places nearly sloughed away. Drainage tubes inserted and wet dressing applied. During these extensive manipulations patient felt very little pain. Respirations and pulse improved at once. Six hours later temperature was 108 degrees and pulse became almost imperceptible. This condition continued a number of hours in spite of vigorous stimulation, ice baths, etc. Rectal injections of supra renal and thyroid extracts were begun with a noticeable effect within a few hours. Patient improved steadily for three weeks, although stomach very irritable and refused to retain anything except the most bland predigested foods. The bowel became rebellious, from the constant enemata and finally refused to retain the supra renal and thyroid. From this time on the patient grew rapidly worse and died in ten days. Had several convulsions just before death. Albumen found in urine each day but no casts. On postmortem large abscess found in the liver and multiple absces-

\*Read before New Mexico Medical Society at 26th Annual Meeting, Las Cruces.

ses in the lungs. Heart much dilated and hypertrophied. Endocardium ulcerated and ulcerations covered with fibrin. Brain apparently normal, no abscesses. Right lobe thyroid contained small encapsulated tumor about  $1\frac{1}{2}$  inches in diameter. Remainder of thyroid riddled with abscesses. Practically all the thyroid tissue destroyed. A careful search was made for a patent thyroglossal duct, but none could be found. Tumor was encapsulated and pathologist pronounced it foetal adenoma. This case remarkable and interesting because of the severe septic thyroiditis implanted upon a gland already the seat of an adenoma:—the noticeable good influence—for a time at least—of the supra renal and thyroid extracts:—the apparent hypothyroidism of the case following the destruction of the gland:—and the septic endocarditis following the other conditions, and following this the metastatic abscesses.

#### Case II.

Mrs. M., a Mexican woman of about 40, who had had a thyroid swelling for several years. She gave the following history: Her father, always well, died at an advanced age. Her mother died at about 50, from some form of fever. Had a tumor of the neck for a number of years before her death. Mrs. M. had had the usual childhood diseases, but otherwise always well. Married at 16. Mother of eight children—all living and well. Oldest daughter married. Since birth of daughter's baby, thyroid had become prominent in the daughter also. Three years ago Mrs. M. noticed swelling of neck and this had continued slowly. Few months before had become inflamed and caused her much distress, after a cold. Now made respirations very difficult at times and was uncomfortable at all times. Examination showed right lobe of thyroid to be much enlarged. Ster-

nomastoid not displaced outwardly but pushed far backward. Tumor was of firm consistence. Left lobe and isthmus normal in size and consistence. Operation under chloroform—anesthetic well given by Dr. Kirkpatrick. Angular incision made over most prominent part of tumor. Capsule very adherent and vascular. Nothing of note in operation except that anastomosing artery of neck of gland spurted freely when divided in medium line. This rather unusual. Became necessary to throw ligature around left portion of isthmus to control hemorrhage. Left lobe left undisturbed. Patient made rapid recovery and left hospital in ten days in good condition. At times had discharging sinus from stump of isthmus. Nine months later had acute inflammation of left lobe after a sore throat and a considerable enlargement followed. She went to another surgeon and had this removed. She has since been in excellent health, but takes thyroid extract constantly. Surgeon who operated on her the second time informs me he found simple thyroiditis with small abscess in substance of gland. Pathologist reports right lobe to have been a simple hypertrophy with colloid degeneration within the acini. Interesting points are, the hereditary history:—the intimate adherence of the capsule following the thyroiditis:—and the large size of the anastomosing artery in the middle line of the isthmus.

#### Case III.

A young man of about 19 years of age gave a history of a slowly growing thyroid tumor since 15 years of age. Six months previous he had had an abscess of liver or empyemia (he did not know which) that had been operated upon. After the operation his condition improved rapidly. Soon afterward, though, the thyroid tumor be-



gan to enlarge and his health began to fail again. I saw him on an afternoon about five, with Dr. Miller of Alamo-gordo. He was much emaciated and in a plainly serious condition. Respirations very much embarrassed, shallow, irregular and about 40 to the minute. Pulse 138, weak, irregular. At times unable to swallow. Could not drink even water when I saw him. The right side of the neck occupied by a large fusiform tumor which appeared to be pulsating. A peculiar bruit could at times be heard with the stethoscope. The least pressure or manipulation could not be made on account of increasing the difficult breathing. The diagnosis was in doubt. It appeared possible that it was a very large aneurism. Immediate operation was advised but not consented to until the next morning. He was placed upon the table and very skillfully anesthetized by Dr. Van Arsdel of Alamogordo. There were present Drs. Kirkpatrick, Gilbert and Miller, the latter two assisting. Tumor was now found to be firm externally, but fluctuating within. Curved incision extending upward and to the right was made and the growth rapidly dissected out. Capsule found to be exceedingly vascular, but very loosely adherent. Operation, including anesthetic which was brought on slowly, occupied an hour and a quarter. Very little hemorrhage took place, as the tissues were carefully divided between clamps. Left lobe unmolested. No hemorrhage in dividing isthmus. Patient went off table in much improved condition and made a very rapid and uneventful recovery. Gained 20 pounds in two weeks' time. Tumor had gross appearance of bronchocele. Was 6 inches long by 4 inches in diameter and weighed 5 pounds. The cortex about  $1\frac{1}{4}$  inches thick was composed of dense fibrous tissue and com-

pressed colloid and glandular material. The center was occupied by a pus cavity containing foul smelling, greenish pus. Pathologist reported cortex composed area nurotic tissue, an infiltrated layer and a layer of hypertrophied glandular tissues with calloid material in acini.

I have chosen these three cases from the six I have operated upon to show the occasional frequency with which benign tumors of the thyroid may be complicated by septic processes. The thyroid is not affected with septic conditions so frequently as other glandular organs, but it is sufficiently so to merit an occasional article in the literature. The works on surgery dismiss the subject with scarcely more than a word. The pathologists merely mention it. Hektven mentions 20 cases and says 14 followed acute diseases and 6 were from unknown causes. Yet it is a condition which may arise at any time, particularly in the puerperal state. It is not always easy to diagnose and may prove rapidly fatal unless very promptly and energetically treated. Owing to the great vascularity of the gland, metastasis is very prone to occur and septic endocarditis may be a fatal complication or sequence. The authorities seem to agree that abscess of thyroid is now prone to occur. 1st. In the puerperal state. 2nd. In degenerative processes of the benign tumor. 3rd. In matastasis from septic conditions in other organs. 4th. Following acute thyroiditis. Thyroiditis may be a sequence of any acute infection, such as typhoid, etc., or it may follow an injury. The greatest number of cases of abscesses follow bronchocele or other abnormal chronic process or acute thyroiditis. My first case reported seems to be almost unique, that is, a case of simple foetal adenoma complicated with acute septic inflammation without any

preceding exciting cause. I herewith append the only six cases on record in the Surgeon General's office where the history of the case is given entire.

Beck (B) Eine Beobachtung uber eitrigen Balgkropf (Struma cystica purulenta). Arch. f. physiol. Heilkunde, Stuttg., 1851, X, pp. 293-300.

Abscesses of a metastatic nature may sometime develop in the thyroid gl., especially in puerperal cases, phlebitis uterina, etc. I have observed two such cases. But I have never known a case where the thyroid with cystic degeneration later on was converted into numerous sacs filled with pus, as in the following case:

A recruit, 21 years old, took cold while helping to put out a fire. He took to bed with a violent bronchitis. He complained of pain in the neck; the right horn of the thyroid gl. enlarged, was sensitive to touch; slight rise of temperature. Application of tr. iodine relieved pain temporarily, but soon returned. Right half of thyroid enlarged to size of two fists. After two months each attack was accompanied by a sense of smothering and swallowing was almost impossible. Patient greatly decreased in weight and looked like a skeleton. Sputum frequently bloody. At this time author took charge of the case. Now enormous swellings of size of three man's fists and hung down over manubrium sterni. Tumor had form of two bags with constriction in middle. Pomum Adami and trachea forced to left. At first it looked like a dilation of art. anonyma and carotis dextra, but closer examination showed the seat in thyroid. Tumor was in places elastic and fluctuation was observed. Diagnosis: Several sacs of thyroid filled with fluid, but could not decide if contents pus. Condition of patient pitiable, extreme emaciation, feet oedematus; patient could scarcely

swallow, extreme difficulty in breathing and weakening diarrhoea. An incision would now have been too late. Patient died of extreme emaciation in a few days.

Postmortem: Opening the largest sack a large quantity of a thick yellowish-gray pus, mixed with dark patches, flowed off. From this empty cavity seven other bags were opened, filled with the same fluid. In the left horn there were three bags or cysts with a dark liquid mixed with bloody coagula, and several smaller pockets and hundreds of small cysts of the size of a pea, filled with pus. Larynx was entirely sound, no ulcers.

As to causation of this tumor, it seems that the thyroid in the beginning was not markedly enlarged; it was simply strumous (as in struma lymphatica). During the exertions in the great cold of this man, a congestion developed in the thyroid and this, with the bursting of some blood vessels and the inflammatory exudate, formed a basis for a further development of the process. (Here much omitted because author's views too antiquated).

In the lungs I found lobular stases, bloody infarctions of the size of a dollar, about 20 in number; in the pleural cavity some liquid, also in the pericardium.

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Wetzlar (L) Fall einer Struma inflammatoria, welche in Eiterung uberging.—Grafe's Jour. d. Chir. u. Augenheilk., Berl., 1837, XXVI, 517-526.

Female, 34 years old. Had in her earlier years several swellings of the glands of neck. In August, 1834, her trouble commenced with a dry, barking cough, which lasted 8 months. In February, 1835, gave birth to seventh child. Very difficult labor. While she was crying she thought she felt the formation of a tumor over the wind-

pipe. During puerperium this tumor increased, became red and painful. The physician who was called in performed blood letting and applied other antiphlog. measures.

Author took charge of case 16 March, '35. Pat. is emaciated, pulse small, (110 p. min.), stool thin, poor appetite, great thirst; difficulty in breathing; constant dry cough. At the front part of neck an intensely red, hard tumor, painful on pressure. Tumor clearly sits on windpipe and seems to follow the movements of the latter and moves from above downward in speaking and coughing. Two wings and a middle piece are easily distinguishable and correspond in form and situation to the glandula thyr. The side wings extend in front to lower jaw and cover behind the sterno-cl. mast. The middle portion extends downward to manubrium of stern. and covers a part of it. Diagnosis: Struma of thyroid. There was a pulsation, but it came from the carotid. The simultaneous movement of the tumor with the trachea excluded the supposition of an aneurysma. But more difficult was the diagnosis of the pulmonary trouble. Dry, barking cough. Percussion and auscult gave nothing abnormal. I might have ascribed the cough to presence of tumor, but patient had cough 8 months before the tumor appeared.

Treatment: Leeches, mercuric ointment, etc., (old fashioned treatment).

Tumor increased, redness, pain and at last fluctuation. Difficult breathing, violent thirst, severe cough, weak pulse, no appetite. Nights sleepless. On 10. of April determined to incise. A large mass of pus and several considerable blood coagula., little bleeding. Incision had been very painful (at that time no anasthes). Pain soon disappeared and patient felt greatly relieved. (Long after treatment.) May 1, 1836.

Patient quite well. Tumor entirely disappeared. October, 1836. Patient had an attack of malaria and neglected it. When at last author was consulted, she was found to be in an advanced stage of consumption; much cough, which appeared six weeks after appearance of malaria. Patient died.

Remarks: Abscess of thyroid is rare; in most cases there existed previously a thyroid tumor. Thyroid becomes inflamed by mechanical injuries. During the chronic inflammation small pus pockets form. In this case probably small blood vessels burst during the effect of a foreign body. That tubercul. was present from the beginning was confirmed by the later outbreak of consumption.

Brunner. (C) Ein Fall von acut eiterger Strumitis, verursacht durch das Bacterium coli commune.—Cor. Bl. f. schweiz. Aerzte Basel, 1892, XXIX, 298-307.

Male, 52 years old, railroad man. Had first a chill, then fever; soon pain in the neck with constipation. Right side of neck began to swell up slowly; called a phys. diagnos. acute strumitis. ice compress. temp. 39 degrees. Then author was called in. Neck stiff; greatly swollen on right side; swelling more diffuse and immovable. At apex fluctuation noticeable. Operat. chloroform anaesth. disinf. of skin. Incision in the direct. of sterno cleidemast in middle of tumor; exposure of a cyst, wall of which is opened; profuse flow of a large quantity of a chocolate colored liquid with a scent like sperma. Finger is inserted in wound; a cavity extending toward the sternum; disinf. with bichloride sol., drainage. Fever disapp., recovery.

Bacteriol. exam. of pus: Bacterium coli commune, no other germs could be developed from pus. A primary abscess formation elsewhere



could not be found. Author thinks bacteria must have come from intestines by means of pathological processes of intest. wall (Pat. had constipation). Bacteria may enter bl. current and settle in certain tissues in body.

Barth. (H). Un cas de thyroidite casenise affectant la forme due goitre suffocant.—France med., Par., 1884, I, 549-553.

Female, 22 years old, came to hospital with swelling of neck; father had been syphilitic. Had in youth eczema, otorrhea, freq. coryza. Is married, two children. She is a washing woman and during her occup. two years ago she had abscesses on leg, with swelling of bones and prolonged suppuration. But she was finally cured. However, the glands of neck became involved, ending in suppuration. Paid little attention to this until her voice was affected and diff. in breathing came. Tumors on side of neck. Diff. in breathing increased and tumor also appeared in front of neck, just above sternum. Respiration is now sonorous, noisy and very difficult at times. Tumor is hard and not movable, occupies the whole thyroid region, glands of neck also enlarged. Auscultation shows signs of pulmonary emphysema well marked; tympanic sound on percuss., especially at base of lung. Patient is in every other way well and robust. Considering the dyspnoea tracheotomy is suggested, but an examination of the tum. renders such an operation impossible. Internally iodide of potass. and ext. merc. ungt. Patient had entered hospital on Dec. 20th and died on Dec. 23rd.

Postmortem: Cervical aponeurosis divided shows a hard tumor of lardaceous consistency which is the median lobe of the degenerated thyroid, recognizable by its capsule. This tumor of size of egg presses trachea back. In-

cising it, it is formed of scirrhous grayish tissue. In it are several irregular cavities with a soft, whitish pulp. Larynx is sound; trachae flattened, at lower end of flattening two small ulcerations. The ganglia on each side of neck have a cardaceous fibroid consistency, but caseous masses are not found here. Lungs are congested, but sound; no caseous masses.

Histolog. exam. of thyroid: Lateral portions unusual texture. Degeneration only in middle portion. Here small vessels obliterated. Toward the center small caseous masses; but trabecula between them not destroyed. Several tests for tubercle bacilli; were negative. This is strange, since the history of case clearly points to scrophulous processes. Dr. Gombian still thinks the process tuberculous, while Dr. Covenil ascribed it to syphilis.

Andelbert: (J. L.) Thyroidite aigue typhoide et kyste hematique du corps thyroide; ponction simple; guérison. J. Med. de Bordeaux, 1888, XVII, 489-502.

Servant girl, 24 years old, came to hospital Dec. 24, 1887, with typh. fever. Ordinary course. On the 9th of January complained of viol. difficulty in breathing and had severe attacks of cough. She felt "as if somebody tried to throttle her with his hands". At the same time a tumor on neck, painful; she said her neck had always been very large. On inquiry her father had also had a tumor on neck contracted after smallpox; same symptoms as she, but had then disappeared. She comes from the Pyrennees, where there is goitre.

Exam.: Tumor size of walnut in the subhyoid region; lower extreme of tumor seems to "plunge" under sternum, also extends under sterno-cl. m. muscles. Tumor somewhat soft, semi-fluctuating, hemispherical; vertical di-

anometer,  $2\frac{1}{2}$  inches, horiz. diam., 3 inches. Swallowing moves tumor from above downward. Much pain. On 10th. tumor enlarged 4 inches across. temp. morning 38 degrees, evening 39 degrees. Appl. of tr. iodine. On the 16th decided to incise, as the diagnosis was made as "hematic" unilocular cyst. Tumor was aspirated; 50 grammes of a reddish liquid, but the last drops are dense, bloody and half pus. The pocket is not entirely emptied and without injecting anything into cavity. Immediate relief. In the evening tumor reappears, but is much smaller. But gradually disappears and patient recovers. On the 29th cure.

The patient coming from a goitre region the basis of this trouble may have been an inherited tendency to goitre. When she took typhoid fever the disease settled in the already abnormal thyroid.

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#### THE SERUM TREATMENT OF PERICARDIAL EFFUSION.\*

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Pericardial effusions have been selected for our mutual consideration because so little has been written upon such an important subject. Text books dismiss it with entirely too little consideration. We shall not, owing to lack of time dwell upon the three stages, but shall confine ourselves to the stage of effusion.

Pericarditis with effusion exists much more frequently than is generally supposed. In a conversation a few months since with one of the ablest surgeons in the south, he stated to me that during a practice of nearly thirty years he did not remember ever to have seen a case of pericarditis with effusion. Such a statement coming from so able a source naturally makes me

ask the question. Is it possible that it does exist and is not recognized? Pericardial effusion may be a serofibrinous hemorrhage, or purulent, all of which I have seen during my clinical courses at the Memphis Hospital Medical College. It may seem dogmatic to some when the essayist makes the statement that the physical signs and symptoms of a pericardial effusion are just as characteristic and just as easy of recognition as the physical signs and symptoms of a pleuritic effusion. The two conditions are frequently confused because the physician has either been careless in his examination of the patient or because he has not properly applied the great fundamental principles of physical signs.

Now let us dwell briefly upon the physical signs of pericardial effusions.

By inspection we learn much. We notice in a great many cases that the apex is not visible. That the patient is suffering from pronounced dyspnoea. This dyspnoea is more marked in pericardial effusions than in any other affection. Cyanosis in some cases, in others it is absent.

As to what we find by inspecting the cardiac region depends entirely upon the degree of effusion. Where the effusion is beginning to form, we often notice tumultuous action of the heart, a corcible apex beat, but when the effusion is large in my experience it is a difficult matter to locate an apex beat by the application of any of the physical signs. By palpation we find that the apex beat is absent when the effusion is marked. That there is no cardiac impulse to the palpating hand. That the pulse is rapid and feeble.

Percussion and Auscultation are the two great physical signs upon which we must depend in making a diagnosis just as we would in a pleuritic effusion.

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\*Read before the Luna County Medical Society, February, 1907.

The area of flatness on pericussion in pericarditis with effusion is characteristic. I use the term flatness with emphasis and advisedly. I wish to call your special attention to the careless indiscriminate and unscientific application of the term flatness, as a synonym of dullness. Flatness and dullness have nothing in common, there is as much difference between them as there is between a tenor note and a soprano note. Yet in a careful reading of all the best books on Physical Diagnosis and Practice of Medicine, you will find the terms flatness and dullness used interchangeably. A fluid medium will not yield dullness on percussion but flatness. You may fill any vessel with any kind of fluid and exclude the air, be that vessel metallic or wooden and by percussing the walls of the containing vessel you will get a flat note. On percussing the heart, where there is a well marked pericardial effusion, we elicit a flat note triangular in shape with the base downwards and the apex upwards. Rotch of Boston, and Obstein of Germany, have called attention to a Phenomenon which I have found as a valuable aid in arriving at a proper diagnosis. I refer to flatness on percussion in the fifth interspace to the right of the sternum. Upon auscultation we will find that the heart sounds are distant and muffled or absent, according to the quality and quantity of the fluid and the state of the valves and the condition of the cardiac muscle. In many cases I have found the heart sound absent, in others the to and fro friction rub at the base, and upon several occasions I have detected a blowing mitral systolic murmur at the apex. This triangular flatness on percussion is the safest of all the physical signs in arriving at a diagnosis. It matters not what may be the evidence by auscultation and palpation. To

confuse a pericardial effusion with a pleuritic effusion is inexcusable, provided the physician has carefully applied his physical signs and has properly interpreted their significance. Yet the mistake is frequently made, I have seen two such instances upon two occasions during the winter of 1902. In pleuritic effusion on the left side there will in nearly every case be displacement of the heart and apex beat to the right. This displacement of apex beat in pleuritic effusion on the left side can always be seen and felt. In pericardial effusion on the other hand if there be cardiac displacement, it will not be to the right, as in pleuritic effusion, but in my experience, upwards. In pericardial effusion in the great majority of cases the apex beat can neither be felt nor seen.

As I stated in the outset of my paper time will not permit discussing the three stages of pericarditis. Suffice it to say that very often at the stage when the effusion is becoming manifest, the heart action is tumultuous, and apex beat is forcible, the heart sounds are accentuated, the pericardial friction rub is often heard. It is therefore well in any case of pericarditis, it matters not what the cause be, to watch carefully for development of effusion just as you would in a simple case of pleurisy. In pleuritic effusion the area of the distribution of flatness on percussion has but little in common with that of a pericardial effusion. In pleuritic effusion, the flatness is marked over the area of the fluid, namely, laterally, anteriorly and posteriorly. In pericardial effusion on the other hand, the area of flatness is over the cardiac region, is triangular in shape with the base downwards and the apex upwards. Upon auscultation in pleuritic effusion there is in the majority of cases absence of voice sounds, and absence of the res-



piratory murmur. In pericardial effusions the respiratory sound is clear and distinct posteriorly and laterally. Bumberger has called attention to an area of tubular breathing at the angle of the scapular in some cases pericardial effusions. I do not attach much importance to this sign as there are too many others which are more significant and more reliable.

In conclusion let us recapitulate and accentuate some facts.

First, do not confuse a flat note on percussion with a dull note; Second, in all cases of suspected pericarditis watch carefully with reference to developing effusions; Third, apply the physical signs carefully and cautiously, thereby saving yourself the embarrassment of confusing pericardial effusion with pleuritic effusions.

—Dr. J. B. Barbee.

#### HEART BLOCK AT NINETY-ONE.

A man dies suddenly at the extreme age of 91; of what did he die? The usual answers: "Old Age," heart failure, senility and exhaustion are vague terms and express nothing to the intelligent physician: To the layman only reminding him that some day his machinery will also wear out but whether by drive wheel, piston rod, or bursting boiler, it would seem immaterial. From a scientific view it is often very interesting to know the exact cause of death, but from a practical standpoint it is of extremely doubtful value in extreme old age. But then again, who knows but that possibly as was suggested to me by a few lines I found one time written on a book leaflet by my father, the so-called second childhood, second manhood, second sight, a late amour, might mean a vain effort but by evolution some day a successful effort of nature to renew life

at the century mark? A very interesting theme to say the least.

A man abuses his anatomy and dies at fifty. Another lives what we think is right and dies at one hundred. Do we know that if a man should live better than what we know at the present time he might reach the extreme age of two hundred? Then is there not some possible value in knowing just why his machinery came to a standstill.

The following case I believe to be of sufficient interest to be recorded in this connection, since it also brings up the extremely interesting condition known as heart block, a state of auriculoventricular dissociation described by Adams in 1827 and by Stokes in 1846, sometimes called Stokes-Adams disease. It has been made of interest recently by the discovery of a bundle of muscle fibers connecting auricle and ventricle and with an explanation of proof of its function by His, Stanley and Erhlinger.

This muscle, called the "Bundle of His" conveys the stimulant to contraction from auricle to ventricle in the normal course of the heart's action, but when interfered with by disease, tumors or deposits its function is altered or entirely cut off producing the symptom complex described as only a Stokes or an Adams could do so many years ago.

This interference with the normal conducting power of this "Bundle" produces alteration in the rythmical association of auricle and ventricle preventing the ventricle from receiving all of the stimulating messages from the auricle thereby producing a slow pulse and by cerebral anemia causing attacks of varied intensity of vertigo, syncope, unconsciousness or convulsions, while at the same time the auricle shows its increased contractions by pulsation of the veins in the neck.

The case I here report presents an additional feature as was shown by the sphygmomanometer, a condition of in-coordinate power of the ventricular contractions, some registering at the wrist long after others had ceased to be felt, the most persistent one occurring every 10 seconds and requiring 129 mm. of mercury to suppress it; during the late periods this dropped to 100.

Case—Judge J. A. P. Age 91, Justice of the Peace. Personal and family history negative, except that wife died of T. B. 15 years ago. Presented himself to me June 9, 1906, complaining of cough, shortness of breath and dizzy spells.

Examination—Fairly well nourished, pale with slight blueness of lips. Eyes show a true arcus senilis, breathes with a catchy inspiration, walks with a cane and is somewhat unsteady. Skin dry and lax, so characteristic of old age.

Chest—Several small dark red spots on lower thorax so often seen in early or cured tubercular cases.

Lungs—Right, prolonged expiration over upper lobe. Impaired resonance. No rales.

Lungs—Left, negative.

Heart—Impulse neither seen nor felt. Sounds are distant but easily differentiated. Not pure but of a muffled character. A beat is missed in every five or six and immediately following this pause two contractions follow in rapid succession. Percussion outline negative. Pulse 50, irregular in that it shows the pause, the two rapid beats not reaching the wrist; artery is tortuous and sclerotic.

Abdomen—Negative.

A diagnosis of arterio-sclerosis with fatty degeneration of the heart was made. Mild tonics with instructions as to care of self were given. He seemed

to improve somewhat and lived fairly comfortably during the following year.

He again visited me in March, 1907, complaining of increased shortness of breath with vertigo. An examination of the heart at that time showed the following:

The systolic contractions were irregular; a pause, amounting to the time of three or four contractions, would occur following a series of about six regular pulsations. During this pause faint contractions(?) could be heard which did not reach the wrist.

Pulse 40, irregular, indicating the pause very distinctly. Audible impulses at heart area 66. Visible venous pulse in neck 90.

Blood pressure by the Rivi Rocci 9 c. m. cuff sphygmomanometer 129 mm. and was peculiar in that some of the pulse beats ceased long before others, the most persistent one occurring every ten seconds and requiring the maximum pressure to stop it. This finally dropped to 100. His condition continued more or less constant, at times showing improvement; at other times worse again. The dizzy spells grew worse and developed into syncopal attacks lasting several minutes. Three weeks before his death the attending nurse described these attacks as beginning with pallor and freight and followed by delirium and unconsciousness lasting several minutes during which time he was pulseless. These attacks occurred every few days toward the last.

He died in one of these attacks on August 15th, just six months after the discovery of the symptoms of heart block.

The post mortem examination revealed an old tubercular focus in upper lobes of right lung producing strong adhesions with puckering at apex, several fibroid nodules size of marbles

with one chalk stone. Tubercle bacilli were obtained from one of these nodules. This tubercular condition was a so-called cure, and did not enter into the clinical picture as I saw it, except the dark red spots on the chest with prolonged expiration and impaired resonance in right lung.

The heart showed extreme fatty degeneration with numerous chalky deposits in both heart and vessels. A large atheromatous deposit  $1\frac{1}{2}$  inches long by  $\frac{1}{4}$  inch thick and of a stony hardness was found in the substance of the auriculo-ventricular septum in a position anatomically that would lead one to suspect that it interfered with the function of the "Bundle of His."

The microscopical examination will no doubt be very interesting.

Charles F. Beeson, M. D.

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*To the Members of the New Mexico Medical Society:*

Gentlemen:

As president of your society I desire to call your attention to the fact that the New Mexico Medical Society stands for ethical medicine and the best interests of the profession generally. The membership of the society can be largely increased by the active efforts of each individual member of the society and while the time for the next annual meeting is some distance in the future it is none too soon for us to begin an active campaign for an increased membership. There is no good reason for an ethical practitioner refusing to become a member of the Territorial organization and there is no good reason for any member failing to impress this upon those who are not members. Recently there have been a large number of reputable physicians who have become residents of this territory and very few—scarcely one per cent—have

become members of the only regular organized body of physicians in the territory. Why this is so I have been unable yet to determine, unless it be that there has been a lack of interest upon the part of our membership to hunt out and gather in these men.

There are seven counties organized and there is room for an organization in several other counties and it is the hope of the president that he may be able to visit not only each existing county society but also those counties where an organization could be supported. As this has to be done at the expense of the individual official it is not quite so easy as it would seem. This being the case I would urge each individual member to aid, as far as in his power, the cause and make a determined effort to bring in at the next meeting at least one application thereby doubling our membership. Application blanks and copies of the constitution and by-laws can be secured from the secretary, Dr. G. S. McLandress, Barnett Building, Albuquerque, New Mexico.

With statehood in sight in the future, and I believe rapid development of the resources of the Territory, will come a larger number of reputable physicians and a larger and stronger medical society. With it all will likewise come a demand for a more rigid medical law and a more careful attention to health matters generally and it seems to me that the union of the physicians as represented in the New Mexico Medical Society will be able to shape the legislation necessary and will be in a position to demand.

It will be a pleasure for me to answer any inquiries and to aid in any way I possibly can the development of the ideas outline above.

Very truly yours,

R. E. McBride, Pres.



**EUCALYPTUS OIL—ITS THERAPEUTIC VALUE.\***

By Edward G. Einz, Pharmacist, Los Angeles.

Knowing, as I do, of the many poor qualities of eucalyptus oil in the market today, prompts me to write an article of this kind.

Oil of eucalyptus, according to the U. S. P., should be distilled from the leaves of the eucalyptus globules only. There being over 100 varieties of eucalyptus, has prompted several, and I dare say, almost all the manufacturers in California, with but few exceptions to distill oil from a mixed collection of eucalyptus, especially the *Amydalina* and *Rostrata*, the yield of oil from the latter being over 3 per cent., while that of the *Eucalyptus globules* is 1 per cent., and not content with that, they are using the woody parts of tree in their process in place of confining themselves to the leaves. This process imparts tar and resin to their product. Another objection to this is that the oil obtained therefrom not only contains tar, resins, aldehydes, but the most objectionable *terpin-phelandrene*, which has no medical virtue as yet known, excepting that an oil containing aldehydes and *phelandrene* is irritating to the mucous membrane, while an oil devoid of *phelandrene* and aldehydes is soothing to the same, while *Eucalyptus globulus* contains no *phelandrene*, but mostly *eucalyptol*, which we all know is the most necessary adjunct of eucalyptus—*eucalyptol* being a strong antiseptic.

The Australian manufacturers of eucalyptus oil are said to pay no particular attention to the variety—men, women and children gather the leaves from a mixed forest and bring them to

the still and sell them. We, therefore, get from that source no true oil of *Eucalyptus globulus*, and it is, therefore, not a good medicinal oil.

The fact that eucalyptus, like balsams and essences, impregnates the mucous membrane in particular, suggests at once the utility to be derived from the drug in inflammatory conditions of the respiratory and urinary mucous passages. It has anti-periodic virtues, in cases in which quinine has either failed or is contra-indicated; in fact eucalyptus is better borne by the digestive system than quinine, fatigues the stomach less; still it would be wholly erroneous to think of eucalyptus as a possible therapeutic equivalent for quinine.

A few words on the special value of the drug in pulmonary tuberculosis will not be out of place, though no rational physician will look for any specific or even curative virtues regarding tuberculosis—in eucalyptus, more than any other drug. It must be confessed that the peculiar antiseptic and anticatarrhal properties place eucalyptus at the head of all remedies from which any amelioration of local tissue decomposition can be expected. In Italy the drug enjoys the enviable reputation of positively benefiting tubercular patients. Dr. Gimbert, of Cannes, a well-known specialist of that famous tubercular sanitarium, expresses himself in terms of highest praise of eucalyptus in various tubercular process. Without contradicting the assertion of these physicians who succeeded in obtaining definite advantages from eucalyptus in tubercular affections, we must express our astonishment that, provided the drug did possess the alleged capacity, such effect should have been wholly unknown in this country. At all events, it appears advisable to exhibit various preparations of eucalyptus in the manifold

\*From the Southern California Practitioner.

affections in which its reputation is either firmly established or merely alleged; it will do no harm in either case, and might be conducive to valuable results in both.

The value of eucalyptus in various catarrhal affections of the genito-urinary apparatus is likewise great. The oil possesses more powerful antiseptic properties than "Phenol" and is accordingly used in an antiseptic spray and for antiseptic dressings. It is not so irritating, but possesses sufficient inflammatory power to render it a good rubefacient if applied with friction. An idea of its antiseptic power may be gathered from the fact that one and one-half parts in 1000 parts arrest the development of bacteria in vegetable infusion. Its effect on the blood is powerful—it diminishes the power of the red corpuscles to absorb oxygen, as can be shown by the darkening of the red blood when a very dilute eucalyptus oil is added to it. It also destroys the contractibility of the white corpuscles—many small insects are paralyzed by the vapor—so the value of eucalyptus as a disinfectant and also as an anthelmintic or vermifuge can be understood. It also acts very successfully in whooping-cough, relieving the whoop and easing the cough as well as paroxysms. The oil may be administered internally with perfect safety in from 5 to 15 minim doses; though in bronchial affections 2 to 3 minims are very efficient. Dr. Thorndyke recommends 10 to 15 minims in case of chronic cystitis, and claims to have obtained very satisfactory results. The oil of *Eucalyptus globulus* is the most satisfactory because it contains the largest percentage of eucalyptol, and is free from phelandrene and aldehydes, and is therefore non-irritating.

#### REPORT OF CASES SHOWING THE NECESSITY OF CARE IN GIVING INSTRUCTIONS TO PATIENTS.

The busy physician, through the years of his active practice meets with many curious cases and comes in contact with all sorts and conditions of humanity. From each case he learns, or should learn, something however little and from each he adds, or should add, some fact to his store of knowledge. The many curious experiences of physicians if recorded in book form would fill more volumes than could comfortably repose on the shelves of a library, public or private, yet it is well at times to report some of the happenings in order that we may call the attention of the profession generally to some of the causes working to prevent the restoration to health of our patient.

From my note books I have taken the cases reported below, not with the idea of adding anything to our sum total of knowledge, but to point out some of the errors into which our patients are sometimes led through ignorance or inattention. These cases demonstrate that the doctor cannot be too careful in making clear to the patient or to the attendant the instructions in a given case, particularly when dealing with those of a minor degree of intelligence. While some of these cases appear amusing in the retrospect, there is a realization on the part of the reporter, at least, of the danger into which each one was placed by carelessness on the part of either the patient or of those in attendance.

The first case is that of a woman of mixed Indian and white blood who was suffering with a rather large abscess of the thigh. A physician was not called until the pus had formed and pointed in the line of least resistance. An incision was made and the abscess evacuated and the cavity dressed ac-

cording to approved methods. As the patient lived in an inaccessible locality daily visits were out of the question and it became necessary to instruct the family as to the future dressings. A solution of lysol as a wash was determined upon and the family shown how to make the solution by using a teaspoonful of lysol in a quart of sterile water. They were ordered to allow the first dressings to remain undisturbed for twenty-four hours after which they were to give daily washings until such time as a second visit could be made.

When the time came for the first cleaning, the dressings were removed and the wound washed with plain warm water and the patient was given a teaspoonful of lysol in a glass of tepid water by the mouth. The mixture was (fortunately) promptly vomited but persistent in the desire to follow instructions the attendant immediately mixed up another dose and forced it into the insulted stomach of the patient with the same firm refusal on the part of the offended organ to retain it. The patient was allowed to rest until next dressing time when the same performance was gone through with after which the husband made his way to the nearest telephone to inform the doctor that while the patient was doing nicely and was much better (as a result of the dosing) yet he feared that the medicine was a little too strong. Investigation determined the condition as outlined above and as a result the proper treatment was immediately instituted. No ill effects followed the heroic medication, but suppose the stomach had retained the medicine, what then?

The second case is that of a negro woman, rather anemic, who was suffering severely with dysmenorrhea. She was given a mild sedative mixture with instructions to take a teaspoonful each

hour until relieved. At the same time an iron, quinine, strychnine and arsenic tonic was ordered, to be taken in teaspoonful doses three times daily. A report next day told the physician that the pains were better but that the medicine had made her quite ill. Further questioning developed the fact that she had taken eight doses of the arsenic and strychnine mixture in as many hours while the sedative mixture peacefully reposed on a shelf in the corner. Fortunately in this case the stomach rejected the unusual dose of arsenic and no ill results followed.

Case three is that of a woman who was given a uterine tonic and a solution of chlorides for a rather profuse leucorrhea. The chloride mixture was to be used in the proportion of a tablespoonful to a quart of water as a vaginal douche while the tonic was to be taken in teaspoonful doses three times a day. By some mischance she used the tonic as she should have used the chloride mixture and attempted to take the latter by the mouth. After several unsuccessful efforts, she reported asking for a change in the medicine inasmuch as she wanted to get well.

The fourth case is one of acute cystitis and general pelvic inflammation in a negro woman. She was ordered, among other things, a suppository containing morphine, belladonna and hyoscyamus. Twelve of the suppositories were given with instructions to insert one into the vagina every fourth hour. This was in the morning and in the afternoon of the same day the husband of the woman returned for another box of "dem pills" saying that they had done his wife much good. The druggist, suspecting something wrong, sent for the physician who discovered by questioning that the husband, the nurse in the case, had inserted four suppositories at the time, repeating the opera-



tion hourly while the suppositories lasted. There were no evil effects although each suppository contained one-half grain of morphine and one-eighth grain of each hyoscyamus and belladonna extract.

In each of these cases the directions were plainly written on the containers and careful directions had been given the attendant as well as the patient. That no ill effects were appreciable in any of them is rather remarkable particularly when the susceptibility of the various patients to the effects of powerful drugs is taken into consideration. It might be argued that the medicines were not up to standard strength, but inasmuch as they were from reputable firms there is no question as to strength.

These cases occurred at varying intervals in the practice of the reporter who does not doubt that many such have come to the notice of every physician and they serve to make clear the point, and perhaps emphasize it some, that too much care can never be used in giving instructions to the ignorant and illiterate.

DR. R. E. McBRIDE.

#### PHYSICIANS' LICENSES ISSUED TO TWENTY.

Santa Fe, N. M., Oct. 16.—The following applicants at yesterday's meeting of the territorial board of health were granted licenses to practice medicine in New Mexico:

Dr. B. B. Bagby, Carrizozo; Dr. Minerva M. Knott, Solano; Dr. W. H. Mason, Estancia; Dr. A. H. Faith, Roswell; Dr. Louis H. Pate, Lake Arthur; Dr. Charles K. Osborne, Las Cruces; Dr. Creighton Ferguson, Socorro; Dr. Frank Brady, Solano; Dr. M. B. Culpepper, Dayton; Dr. Howard Crutchen, Roswell; Dr. Charles

A. Miller, Tularosa; Dr. Isaac N. Woodman, Taos; Dr. George E. Fuller, White Oaks; Dr. John L. Cass, Roswell; Dr. D. B. McPherson, Malaga; Dr. W. E. Currie, Santa Fe; Dr. David E. Furnall, Albuquerque; Dr. Walter A. Bayley, Dawson; Dr. E. T. Wilkinson, Clovis; Dr. Samuel M. Crume, Las Vegas; Dr. Sylvester Van Alman, Clovis.

Five other applicants for licenses to practice medicine in the territory were given a written examination today on various subjects embraced in materia medica. They were Dr. H. F. Vandever, Portales; Dr. Jose Somellera, Trinidad; Dr. Preston Worley Clovis; Dr. W. H. Jones, Santa Fe, and Dr. W. E. Sunderland, Albuquerque.

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We clip the following editorial from the November number of Colorado Medicine:

#### No Proprietaries for Silver City, N. M.

To Silver City, N. M., a flourishing town of 3,000, belongs the credit of successful co-operation, on the part of the twelve physicians practicing there, in the excluding of proprietary medicines from their prescriptions.

According to Dr. Geo. K. Angle, of that city, who was a recent visitor in Denver, the physicians agreed to familiarize themselves with the preparations of the United States Pharmacopoeia and National Formulary, and to use them exclusively. The doctor remarked incidentally that the druggists did not keep them, and that they could not be procured in the city, and that detail men spent little time there.

We congratulate the Grant County Medical Society for its action as outlined above and we sincerely hope that other county societies will profit by its example and do likewise.

**EXOPHTHALMIC GOITRE.**

—Harriet C. B. Alexander\* discusses the subject and reports thirteen cases. Four principal theories of the disease have been advanced: 1. That it is due to disease of the sympathetic nervous system; 2. that the seat of the malady is the medulla oblongata; 3. That it is primarily a disease of the thyroid gland; and 4. That it is a neurosis.

Modern therapeutic measures have been largely based on the "thyroid" theory. The results of partial strumectomy indicate that the successful removal of a portion of the thyroid gland can lead to cure or to definite amelioration of the condition. On the theory that the thyroid secretion normally neutralizes certain general metabolic poisons in the body, Moebius and others conceived of treating cases of exophthalmic goitre, in which there is presumably an excess of thyroid secretion in the body, by introducing subcutaneously, or by the mouth, the serum of thyroidectomized animals. It was hoped that the non-neutralized general metabolic poisons of such animals would nullify the toxic effect of the excessive thyroid secretion. As to the treatment experience has shown the great importance of general measures: complete rest for a time, fresh air, careful diet, mild balneotherapy, etc.

The name Thyroidectin has been given to a preparation obtained under aseptic precautions from the blood of animals from which the thyroid glands have been removed, and which is exhibited as a reddish brown powder contained in capsules, usually five grains each. Carefully conducted clinical trials seem to show that Thyroidectin can be depended upon to control the characteristic symptoms of exoph-

thalmic goitre. In most cases the patient experiences much relief from the restlessness, tremors, insomnia and other nervous symptoms so frequently present, and a gradual lessening of the frequency of the pulse rate, decrease in the size of the glands, and a diminution of the exophthalmos, with an increase of weight and a much better condition generally. The dose of Thyroidectin seems to be one or more capsules after each meal, according to the judgment of the physician and the reaction of the patient.

In nine of the author's thirteen cases the size of the gland was materially reduced, and in every case improvement was observed with respect to one or more of the symptoms.

**EXCISION OF THE ANKLE.**

By J. B. Cutter, M. D., Surgeon to A. T. & S. F. Ry., Coast Lines, Albuquerque, N. M.

The term expressed in the title of this paper refers more particularly to the operation involving the removal of the tibio-tarsal joint, though it is often used to cover more extensive procedures, sometimes involving the removal of the astragalus.

The operation was introduced by Moreau in 1792, but the purposes reached by the operation have in later years been obtained by the more radical operations of amputation after the method introduced by Syme and Dr. Stephen Smith.

Skillfully performed, however, I consider the excision of the ankle joint and removal of the astragalus, especially in compound fractures or luxation involving this bone, a justifiable and satisfactory procedure.

I recently had occasion to remove the astragalus in a case of extensive mutilating injury at the lower extremity, the bone being completely dislocated and separated from its cartila-

\*The American Practitioner and News, August, 1907.

genous attachments. Technically the result was all that could be desired.

Prof. Lewis A. Stimson recommends the operation and gives good account of the results in his own experience.

The operation is adaptable to serious deformity following the provincial treatment of Potts fracture.

The operation may be done by two lateral incisions, one posterior to either malleolus, or better still by semi lunar incision passing around the lower border of the outer malleolus and continued longitudinally in the line of the fibula. The anterior extremity should not be extended far enough to part the extensor tendons or dorsal artery, of course. After severing the peroneal tendons, remove the styloid tip of the fibula; do this with the Gigly saw or cutting forceps, leaving the tip of the bone and the bones of the foot attached.

In cases of acute traumatic origin the lines of incision must be influenced by the circumstances of the trauma, when only a part of the astragalus may be taken; but disease of this bone being the motive of the operation, the bone should be extirpated.

The foot is inverted and at this juncture two procedures present themselves for election: First: Clear the end of the tibia with knife, cutting away the internal malleolus, then remove as much of the tibia as is required. Second: Make a short internal incision and divide the tibia by sawing across from one side to the other.

The after-treatment requires as its essential feature the immobilizing of the foot and leg in a correct position until complete ankylosis has resulted.

Cullbertson collected 124 cases done for diseased condition of which only 10 died.

Arthritis, caries, or trauma are the usual causes, and my experience with

the latter class of cases has been satisfactory.

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#### DANGER TO DOCTORS.

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It seems that the greatest danger the doctor has to contend with is not contagious disease or stress of weather or the night highwayman, but that it is woman, designing, malicious women, either disgraced, about to be, or desiring to be. In looking over the reports of deaths among physicians, comparatively few are reported to be from contagious diseases. A reputable physician of Detroit has recently undergone an experience which makes the average doctor shudder and look about for a chaperone. Dr. E. L. Emmons was called to visit a patient whom he had never visited before. He found her in a boarding house complaining of the symptoms of a hard cold, for which he prescribed. He did not hear from her again til a week or two later, when he read in the papers that the woman had accused him of procuring an abortion on her. She was a janitress and was found by another physician suffering from sepsis due to a blundering attempt to procure an abortion. Another physician was called in and the patient removed to the hospital. The prosecutor's office was notified and the assistant prosecutor and a stenographer hastened to the bedside to take the antimortem statement. The priest having administered the last sacrament, facing death and in the presence of several witnesses she said that Dr. Emmons had performed the operation, named the time place and fee. But she did not die. A month later the case was brought to trial and instead of the antimortem statement the woman herself was on the stand. On cross-examination she broke down and admitted that Dr. Emmons knew nothing at all about



the case or her condition. She said she thought that she would be sent to prison herself if she did not accuse some one. Think of the fate of Dr. Emons had she died with that awful lie upon her lips. Laws should be passed making it a crime to solicit a physician to commit an abortion as well as to offer a bribe, and the laws should be made to better protect physicians from blackmail and accusations of this kind.—E. M. S. in *Am. Med. Compend.*

### MANUFACTURING PHARMACY.

(Excerpt from address by Dr. Solomon Solis-Cohen, Philadelphia, Chairman of the Delegation from the section on Pharmacology and Therapeutics of The American Medical Association to the Meeting of The American Pharmaceutical Association.)

"For the last few years pharmacists and physicians working hand in hand, have set themselves to change some of their mutual errors and mistakes of the past. It lies not in the mouth of the physician to reproach the pharmacist, nor in the mouth of the pharmacist to reproach the physician. We have erred mutually, we have erred together, and we are determined to redeem ourselves together. The mere trade in patent medicines, in frauds and fakes, the deceptions of all kinds, need not concern us. There are crimes outside of the ranks of medicine and outside of the ranks of pharmacy and we are not starting off on a general reform expedition. There are other organizations and other agencies for that purpose, but the movement to make the drugs—whether the product of the manufacturing houses or the product of the individual pharmacist—which are dispensed over the counter upon our prescriptions, what they purport to be is one in which you and we have a common interest, and in which our patients have the greatest interest of all. I recognize and you recognize—we must recognize—that in the general progress of science and the general advance of discovery, and the general progress of the arts of manufacturing and preparation of crude pharmaceuticals there is abundant room for large manufacturing houses which devote themselves to specialties of various kinds.

"For example, how can the individual pharmacist undertake to prepare and supply the great group of animal extracts and

serums, which now have such a large part in the therapeutics of today? And so even with various galenicals, alkaloids and the like. There are many things which the retail pharmacist cannot do as well as that establishment which possesses the proper facilities and which is thoroughly organized to do well on a large scale what can only be done imperfectly on a small scale. We all recognize that, and the American Medical Association has taken steps, individual physicians have taken steps, to place themselves in proper relation with the great manufacturing houses, which are a credit to American Pharmacy and to American business. We want to have the most cordial relations with them, so that these firms may be encouraged to prepare and offer to us for the benefit of our patients the best and purest and most definite pharmaceutical products. And yet, after all there is a place, and there must be a place always for the individual pharmacist—the retail druggist, call him by whatever name you please; for the individual who practices as a scientific man the profession of pharmacy."

### ORIGIN OF WHOOPING COUGH.

Whooping Cough while long considered as among the diseases which are of bacterial origin has never been definitely associated with any specific organism. Wollstin has lately shown that Whooping Cough can be shown to be definitely associated with one organism. He demonstrated this by a test of the agglutinating power of the patient's blood upon the organism, and was successful in isolating the same organism in practically all developed cases of Whooping Cough during the first seven or eight weeks of the disease. Before the "whoop" appeared it was impossible to isolate the bacteria, but after the diagnosis was settled, the isolation was satisfactory. The *Pertussis bacillus* closely resembles *influenza bacillus* and there is strong evidence to show that the two organisms belong to the same group.

In Selma, California, tuberculosis is placarded the same as other contagious diseases.

### MARRIAGES.

Chas. Wm. Gerber, Las Cruces, to Geraldine Clark Combs of Linneus Mo., Sept. 11th.

Dr. J. J. Witscher of Silver City, to Miss E. M. Nash of Philadelphia, at Albuquerque, Oct. 30th.

Dr. Water A. Bayley of Dawson, to Miss Chase of Los Angeles, recently.

(Resolutions adopted by the Executive Committee of the American National Red Cross, October 18, 1907.)

Whereas, By international agreement in the Treaty of Geneva, 1864, and the revised Treaty of Geneva, 1906, "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross" were adopted to designate the personnel protected by this Convention, and

Whereas, The Treaty further provides (Article 23) that "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross can only be used whether in time of peace or war, to protect or designate sanitary formations and establishments, the personnel and material protected by this Convention" and

Whereas, The American National Red Cross comes under the regulations of this Treaty according to Article 10, "volunteer aid societies, duly recognized and authority having been conferred upon the American National Red Cross in the Charter granted by Congress, January 5, 1905, Sec. 2, "The corporation hereby created is designated as the organization which is authorized to act in matters of relief under said Treaty", and, furthermore,

Whereas, In the Revised Treaty of Geneva, 1906, in Article 27, it is provided that "the signatory powers whose legislation should not now be adequate, engage to take or recommend to their legislatures such measures as may be necessary to prevent the use by private persons or by societies other than those upon which this Convention confers the right thereto of the emblem or name of the Red Cross or Geneva Cross",

Be It Resolved, That the Executive Committee of the American National Red Cross requests that all hospitals, health departments and like institutions kindly desist from the use of the Red Cross created for the special purpose mentioned above, and suggests that for it should be substituted

some other insignia, such as a green St. Andrew's Cross on a white ground, to be named the "Hospital Cross", and used to designate all hospitals (save such as are under the Medical Departments of the Army and Navy and the authorized volunteer aid society of the Government), all health departments and like institutions, and, further,

Be It Resolved. That the Executive Committee of the American National Red Cross likewise requests that all individuals or business firms and corporations who employ the Geneva Red Cross for business purposes, kindly desist from such use, gradually withdrawing its employment and substituting some other distinguishing mark.

### IMPARTED RADIO-ACTIVITY.

The most remarkable property of the emanation from thorium is its power to impart temporary radio-activity of a specific kind to solid bodies with which it comes into contact.

If a thorium compound is kept in a closed vessel for several hours so that the emanation is retained, the interior of the vessel after the removal of the thorium is itself strongly radio-active. The rays from this imparted radio-activity are distinct from this of the thorium itself, being more penetrating. All objects become radio-active in this manner and the imparted radio-activity is of the same character.

If the surface of the body made active, is scrubbed with sand-paper, the activity is transferred to the sand-paper. It is possible to concentrate the whole of the imparted radio-activity on a fine wire, so that the wire is weight for weight, many times more active than the original thorium compound. —Red Cross Notes.

Prof. Behring's new serum is now offered under the title "Tuluse."

To Lord Lister belongs the credit of having shown the way to the successful employment of animal tissue, as a ligature and suture material.—Senn.

### THE DURATION OF LIFE.

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An animal lives five times as long as it requires to complete the development of its skeleton. The camel completes the development of its skeleton at the age of eight years, the horse at five years, the ox at four years, the lion at four years, the dog at two years, the cat at one and one-half years, and the rabbit at one year of age; while the average duration of life in these animals is as follows: The camel forty years, the horse twenty-five years, the ox twenty years, the lion twenty years, the dog ten years, the cat seven and one-half years, and the rabbit five years. The duration of life of the elephant is not known. The older authorities assert that the elephant lives from four hundred to five hundred years; Aristotle and Buffon stated one hundred years; but to ascertain this accurately statistics for long periods of time must be kept. As the development of the human skeleton is complete at about the twentieth year, the natural duration of life of man should be about one hundred years.—Red Cross Notes.

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### She Managed It All Right.

A physician, in order to maintain a wholesome atmosphere in sleeping-rooms, laid in a stock of thermometers, which were distributed to his patients in those households where they were most needed. He took pains to point out to each family in turn just how the thermometer would indicate the proper degree of temperature.

In making his rounds one day he inquired of the woman at the head of one establishment, wherein he observed his thermometer proudly displayed at the end of a string, whether she had followed his instructions.

"Yes, sir," answered she, "I'm very careful about the temperature. I watch the thing all the time as it hangs up there."

"What do you do when the temperature rises above sixty-eight?" asked the doctor.

"I take it down, sir, an' put it outside till it cools off a bit."—Ladies' Home Journal.

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### HUMOROUS.

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"A little nonsense now and then,  
Is relished by the wisest men."  
—Anonymous.

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### The Human Body.

A pupil in a village school, who had been requested to write an essay on the human body, handed in the following:

"The human body consists of the head, thorax, abdomen and legs. The head contains the brains, in case there are any. The thorax contains the heart and lungs, also liver and lights. The abdomen contains the bowels, of which there are five—a, e, i, o, u, and sometimes w and y. The legs extend from the abdomen to the floor, and have hinges at the top and middle to enable a fellow to sit when standing or to stand when sitting."—Tex. Med. News.

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### A Mark Twain Story.

Mark Twain once received a letter from his brother, who complained that he was afflicted with a boil and the jumping toothache at the same time, and inquired if he had ever heard of a worse combination.

"No," wrote the sympathetic "Mark," "and I can imagine only one that might be worse—that would be to have inflammatory rheumatism and St. Vitus' dance at the same time!"—Edith Brownwell, in April Lippincott's.



**Working Sick and Well.**

"Did Dr. Sharp make all his money from his practice?"

"Oh, my, no! He's the principal owner of a very large oil well up the State, and—"

"Ah! I see; he makes his money from the sick and well, too!"—Los Angeles Journ. of Ec. Med.

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"Where was he struck by the automobile?" asked the coroner. "At the junction of the dorsal and cervical vertebrae," answered the surgeon. "Will you please point that out on the map?" asked the coroner, indicating one that hung on the wall.—Chicago Tribune.

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**The Chorus Girl.**

The chorus girl, hitherto known only behind the footlights, is now beginning to attract attention off the stage.

Chorus girls are found in all parts of the intemperate regions as far west as Omaha, as far east as Williamsburg, and as far south as Fourteenth Street. They range in height from four to seven feet, and in depth according to your resources.

They are animal, vegetable, and mineral, and when analyzed assay about four pounds of brass to the ton.

Chorus girls subsist on all kinds of foods, drinks, chappies, and angels. When not employed, they often move in the best of society.

The age of the chorus girl varies from 14 to 114.

The origin of the chorus girl is lost in obscurity, but she is supposed to have come from Kentucky via the Boston Back Bay.—Life.

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**Discovery.**

A young Iowa doctor has made the discovery that the ankle is placed between the foot and the knee in order to

keep the calf away from the corn. Looks reasonable, don't it?—Oklahoma Med. News Jour.

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H. S. Chapin tells of a thrilling automobile experience he once went through. He was traveling in a far country, and came to a town where they told him there was a splendid building that had been put up as a lunatic asylum, specially for automobilists. Being curious to see this place, Chapin by a little effort succeeded in being led through the building, which was large and spacious and fitted up with every luxury. Not seeing any of the patients he asked where they were.

"The patients?" replied the guide. "Why, they are all lying on their backs under the beds workin' on the slats."—Automobile Magazine.

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Owing to the overcrowded condition of our columns a number of births and deaths are unavoidably postponed this week.—Leesville (Mo.) Light.

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**A Little Knowledge.**

A widow woman, resident of New York, lately underwent an operation for removal of a fibroid tumor of the uterus. Removal of the growth took place through an anterior abdominal incision, which left the usual scar. In discussing this phase of the matter, one of her female friends exclaimed that it was all wrong for her to have submitted to such an operation. "For," she said, "the best surgeons nowadays never remove a tumor that way, but reach it by cutting through the pajama, when, of course, there is no scar."—Chicago Med. Rec.

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**Differential Diagnosis.**

He came up for his final examination in Obstetrics and was rather ner-

vous. The examiner put the question, "Now, suppose you were called to a woman in labor, whom you had not examined before, what would be your first care?"

"To—er—determine the presentation."

"Right. Now, how would you differentiate between a face and a breech?"

"Why—er—er—if it was a breech I would recognize the arms, and—er"

"But how would you know that it was not the mouth?"

He hesitated—and was lost.

At length a brilliant thought came to him, he threw back his shoulders and blurted out confidently. "Why, because, if it was the mouth I would recognize it by the teeth!"

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#### Modified Milk.

A lot of poor children were at a farm. The farmer gave them some milk to drink, the product of a prize cow.

"How do you like it?" he asked, when they had finished.

"Gee, it's fine!" said one little fellow, who added, after a thoughtful pause, "I wish our milkman kept a cow!"—Cardiff Times.

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#### Etymological Inconsistency.

"I tell you," said a bright young freshman, "a whole lot of these Latin names are wrong. Take 'os uteri,' for instance. Who ever heard of a uterus with a bone in it?"—Med. Visitor.

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#### The Mills of the Gods.

He rushed out of the elevator and forced his way through the crowd, which pressed against the gate, mut-

tering as he did so, "Excuse me, sir," "Pardon, madam."

St. Peter looked him over critically, then asked:

"Name?"

"I. Keen Cutter."

"Business or profession?"

"Surgeon!"

"General or Special?"

"Sir, I was the leading gynecologist in—"

St. Peter sorrowfully shook his head, then, muttering something into his beard that sounded like "Race Suicide!" pointed before him as he cried in a loud voice, "First car on the left, Going Down!"

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Gladys (age five): O Dorothy! did you know we've got a new baby at our house? It came yesterday. Dr. S—— brought it.

Dorothy (age five): No, I didn't. How nice! You know we had one at our house last summer—but we take of Dr. C——.—Hospital Topics.

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#### A Stinging Rebuke.

A certain physician living in the northern part of Nebraska, recently sent a bill for services rendered, and a few days after received his bill back, endorsed as follows:

"Dear Sir: This notice was put in my box and opened by mistake. The party has been dead for about three months, and is no relation to me whatever. It is strange how a doctor's conscience will allow him to dun the dead. You must live a better Christian life, and live and let live, and try and meet this lady in heaven, which is worth more than \$41.50 to any doctor."

**In Crab Land.**

Professor Skinner—"Mr. Dullboy, what kind of parasites infest the public region?"

Dullboy (hesitatingly)—"Oh, yes, professor; cockroaches."

/—/

**A Postscript Prescription—Let It Go.**

Has a neighbor done you wrong,

Let it go.

Let his weakness make you strong;  
Help to cheer the world with song.  
Hatred never rights a wrong,

Let it go.

Have you missed your heart's desire,

Let it go.

Don't lose courage, still aspire;  
Gold, you know, is tried by fire;  
Moaning ne'er will lift you higher.

Let it go.

Do you differ with a friend,

Let it go.

Argue not, lest friendships end;  
Better far good will to lend,  
Time the trouble soon will mend,

Let it go.

In your past is there a stain,

Let it go.

If its memory gives you pain,  
Drive it out—'twill be your gain;  
Cheerful thoughts will banish pain,

Let it go.

Does your body hold an ill,

Let it go.

Waste no time with drug or pill  
There's a way better still,  
Seek the woodland and the rill,

Let it go.

—Ann R.

Hear me, Anna, fee is nil,

Oh dear no.

Does your body hold an ill,

R

Take a great big C. C. pill,

Sig.

Then seek the woodland and the rill

And

Let it go!

—S. Q. Lapius, M. D.

/—/

**Mary Up to Date.**

Mary had a little goat,

His given name was Bill,

And everywhere that Mary went

The goat went too, until

They met a wicked doctor man,

And had a business session;

Bill's testicles are now in lymph—

His thoughts defy expression!

/—/

**The Bacillus Agnostic.**

In from his rural dominion,

Fresh from his rustic location,

Came the bacillus agnostic,

Rank disbeliever in microbes.

Talked he right bold to the doctors—

Those who believe in the ptomaines

Thus spake Reub sore on such folly:

"Long years ago in the country

Had we a place called a school-house;

Always without ventilation,

Ever without any safeguard

'Gainst the onslaught of disease.

Never an oven for pencils,

Never a book fumigator,

Never a bit of precaution

Other than such as the beasts have.



(Some asafetida surely,  
 Eke, some small baglets of sulphur.)  
 Drank all we brats from one tincup,  
 Aye, from one bucket we guzzled;  
 Some even poured back their leavings!  
 Sometimes a slate that was borrowed,  
 Bearing nine kinds of dried moisture,  
 Had to be cleaned before using—  
 Used we our tongues for the cleaning.  
 Yet there were none of us ailing;  
 Ne'er had we heard of the microbe."  
 Thus said the bacillus agnostic,  
 Rank disbeliever in ptomaines.  
 Silence from all of the doctors.

—Indianapolis Journal.

/—/

#### Dr. Knopf's Treatment.

One doctor called it liver,  
 Another called it lung;  
 One labored to diskiver  
 A cancer on his tongue.  
  
 One recommended mountains,  
 Another spoke of springs,  
 Of Carlsbad's bubbling fountains  
 And other costly things.  
  
 At last a doctor saintly  
 Applied mud-plasters warm,  
 Whereat the patient faintly  
 Wailed, "Pass the chloroform."  
  
 "To dreamless, cheap aphasia  
 I fain would flutter hence;  
 Please give me euthanasia  
 And save this demd expense!"

Copies of the "Great American Fraud" pamphlet, a reprint of the famous articles in Collier's Weekly, which were compiled by Mr. Adams, after a vast amount of personal investigation, should be in the hands of every physician. It is gratifying to learn that the Jackson County Society has purchased a sufficient number to supply not only every member, but every physician in the county as well. The edition, now being supplied at a nominal cost (\$2.00 for 50 copies) by the American Medical Association, includes the two series, the first on "The Nostrum Evil" and the second on "Quacks and Quackery." They form a relentless expose of the ridiculous claims of the patent medicine man and the miracle workers, and can with propriety be put into the hands of his patients by the physician. The secretary of each county should supply the members on his list, with one or more copies.

The Health Department in New York City distributes cards upon which are printed rules for tuberculosis patients. Our members should influence their local health officers to impress upon the public the contagiousness of tuberculosis, by circulating a similar set of rules. The principal points on the New York card are:

Don't live, study, or sleep in rooms where there is no fresh air.

Don't live in dusty air. Get rid of dust by moping with map cloths. Don't sweep with a dry broom.

Keep one window partly open in your bedroom at night and air the room two or three times a day.

Don't eat with soiled hands. Wash them first.

Don't put hands or pencils in the mouth or any candy or chewing gum other persons have used.

Don't keep soiled handkerchiefs in your pocket.

Take a warm bath at least once a week.

To those who have contracted consumption:

Don't waste your time on patent medicines. If you go to a doctor in time you can be cured.

Don't drink whiskey or any other form of liquor.

Don't sleep in the same bed with anyone else, and, if possible, not in the same room.

Good food, fresh air and rest are the best cures. Keep in the sunlight as much as possible.

Keep your windows open winter and summer, day and night.

The careful and clean consumptive is not dangerous to those with whom he lives and works.

The following rules are enjoined on even healthy persons, and they are asked to observe them:

Don't spit on sidewalks, floors or hallways. Spit into the gutters or a spittoon half filled with water.

Don't cough or sneeze without holding a handkerchief before the face.

#### SAFE THERE.

"Yes," said Mrs. Hauskeep, "I just had to buy this plain gown on account of my cook."

"I don't understand," said Mrs. Naybor.

"Why, you see, she just goes in for gaudy things and I want just one dress she won't copy."—Philadelphia Press.

Benevolent Lady—But, my poor man, if you have been looking for work all these years, why is it that you have never found it?

Tramp (confidentially)—It's luck, mum—just sheer good luck.—Tit-Bits.

SO 'TWOULD SEEM.

Gaddie—You don't seem to consider my opinions very valuable.

Krochett—Well, you don't seem to think so, either.

Gaddie—Why?

Krochett—Because if you did you wouldn't give them so freely.—Philadelphia Press.

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## CONTENTS

Editorial .....	3
Uncinariasis, Dr. John W. Colbert.....	5
Pelvic Diseases of Women, Dr. J. H. Wroth .....	10
Scarlet Fever, Dr. R. E. McBride.....	16
Report of Special Health Officer, Hon. B. Ruppe .....	18
A Plea for Reasonable Harmony, Dr. G. K. Angle .....	20
An Unusual Hysterectomy, Dr. Howard Crutcher .....	22
Miscellany .....	23
Book Reviews .....	26

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**EDITORIAL**

The committee of the synod of the Presbyterian church of Arizona and New Mexico, which was appointed for the purpose of selecting a site for a sanatorium for the treatment of tuberculosis, has chosen a plot of ground near the city of Albuquerque, and will at once use every means at its command to prosecute its plans.

While the object of the committee is to establish a hospital for the treatment of tuberculosis, it is understood that the scheme includes the building of a general hospital for the care of all medical and surgical cases.

It is to be hoped that the prospectus will be endorsed by the General Assembly of the Presbyterian church thereby creating a National Sanitor-

ium for this denomination. It is possible that the Home for Disabled Ministers, which is endowed with \$50,000 will be located here and operated in connection with the sanatorium.

The Southwestern Presbyterian Sanatorium is incorporated with the following directors named:

Rev. H. A. Cooper, Albuquerque.  
Judge Jno. R. McFie, Santa Fe.  
Mr. R. R. Larkin, Las Vegas.  
Dr. W. G. Hope, Albuquerque.  
Dr. W. P. Sipe, Flagstaff, Ariz.  
Rev. Jno. Meeker, Alamogordo.  
Mr. T. L. Lowe, Silver City.

The International Congress on Tuberculosis which will meet at Washington, D. C., in September of this year will be an unique event in the new world for it has never met in America and may not meet here again for many years to come.

This Congress meets every three years and at the coming meeting public discussions of the tuberculosis problem will last for three weeks; there will be clinics and demonstrations during the whole of this time, and a tuberculosis exposition in which will be shown what is going on in the campaign against the great white plague the world over.

Of the nine departments of the Federal Government, seven will participate; thirty-seven of the State Governments have committees now at work, and without doubt all of our States together with their governors will take an active interest and combine for the purpose of securing for each the utmost benefit from this Congress. Nearly every foreign country is interested and will send representatives.

It is estimated that the proceedings of this Congress will require four volumes; these publications will be most



valuable and will be sent to all active members free of charge.

The importance of this Congress to the men of this particular part of the country cannot be estimated and it is to be hoped that New Mexico will be well represented.

Any amount of information regarding the International Congress on Tuberculosis, can be secured by addressing the Secretary-General, 714 Colorado Building, Washington, D. C.

Upon another page will be found the report of Major Bernard Ruppe to the Territorial Board of Health, and it is printed in full because of the many points of interest therein to the profession of New Mexico. The board is to be congratulated upon having such an able and efficient officer, and we believe the various suggestions offered in this report should inspire thoughtful consideration on the part of the members of the Board at their next meeting.

We agree that every county Health Officer should be provided with a list of registered physicians, and should be informed of any additional, directly after the meetings of the Licensing Board. This would save many embarrassments for the referee in search for information, and expedite matters upon occasions where it is necessary to prosecute an illegal practitioner.

It also appears that we are laboring under some disadvantage regarding the matter of fines; where it is absolutely necessary to prosecute, we believe the cost of such prosecution should not exceed the minimum fine; a small fine may be somewhat of an incentive for many a man to take chances with the Board, for it offers an opportunity to practice unmolested for any length of time in some out of the way place.

Our population is growing so fast that great inducements are held out to practitioners of all kinds to locate in the Territory. While we should welcome those who are qualified and willing to comply with our laws, we would do well to protect our profession and people to the limit against charlatans and imposters who have no regard for the law and evade it whenever possible.

---

Dr. B. D. Black, who died from an acute attack of pneumonia at his home in Las Vegas, N. M., on the 6th day of February, 1908, was born at Richland Center, Wisconsin, on the 24th day of August, 1874. His early education was received in the schools of Richland Center. He entered the University of Wisconsin in the fall of 1892, remaining there for a period of two years, devoting his time to the academic course preparatory to the study of medicine. In the fall of 1894 he matriculated at Rush Medical College, graduating with highest honors in May, 1897. After completing his medical course he served an internship under Dr. Albert J. Ochsner, at Augustana Hospital, Chicago. Following his hospital service he took up his residence in Lead, South Dakota, in the capacity of surgeon to the Home Stake Mining Company which company he served for a period of two years. The stress of the company practice and rigor of the northern winters so impaired his health that he came to New Mexico in 1901 seeking a more salubrious climate. Shortly after his arrival in Las Vegas he was appointed City Physician, which office he later resigned to give more attention to his rapidly growing practice. During the administration of Governor Miguel A. Otero, he was ap-

pointed Secretary of the Territorial Board of Health, and also a trustee of the Territorial Insane Asylum which position he held at the time of his death. He took an active part in municipal affairs and served the city as a member of the Board of Education and of the City Council. In character, temperament and mentality Dr. Black was pre-eminently adapted to the practice of medicine. His alert mind and keen perception enabled him to reach at once conclusions in diagnosis which are ordinarily attained after profound study and reflection. His cheerfulness and buoyancy of spirit inspired confidence to a marked degree and made all with whom he came in contact feel the force of his magnetic personality.

In his social life, Dr. Black was a man of unusual attainment, thoroughly familiar with classic and current literature. He possessed a high order of intelligence, the scope of which was a constant surprise and delight to all who knew him,—a gifted musician, a pleasing recanteur, he readily became the life and central figure of any company in which he might be found. A courteous gentleman, a genial host, he possessed a rare affability which made for him many loyal friends throughout the entire Territory.

It is given to but few to achieve in so short a time, such a splendid success as that attained by Dr. Black. But thirty-three years of age he left a record in his professional and civic life to which any man of mature years might well have looked with pride.

Perhaps the most striking characteristic in the life of Dr. Black, was his devotion to his profession,—for those who knew him best attribute his untimely death to fatigue and exposure incidental to his work.

### UNCINARIASIS.

#### Report of Five Thousand Cases Treated in Porto Rico.

(By Dr. John W. Colbert, Surgeon to A. T. & S. F. Ry., Coast Lines, Albuquerque, N. M.)

Despite the great amount of literature, both lay and medical, on Uncinariasis in recent years, but few physicians are today acquainted with the condition, and but few laymen are familiar with the story of destruction that this disease has caused in the families of the unfortunate country people of the fair island of Porto Rico. To my mind it is one of the most pitiable stories in the annals of modern medicine.

Uncinariasis, or "Anaemia" is today the scourge of Porto Rico. It causes more suffering and sorrow, more deaths, and a greater economic loss than any other agency, not even excepting Yellow Fever in its palmiest days. From 6,000 to 8,000 people die of the disease every year, more than 25 per cent. of the total death rate. Ninety per cent. of the rural population, or eight hundred thousand of her one million inhabitants are victims of this plague.

Yellow Fever was unusually prevalent in the year 1905. Our own country was aroused at its outbreak in the Southern States, and every effort of science and enormous sums of money were used to prevent its spreading, yet in all the world there were not so many deaths in the year 1905 from Yellow Fever as there were deaths from Uncinariasis the same year in Porto Rico.

A few observations gained from the treatment of 5,000 cases of this disease in Porto Rico may be of interest, especially to the profession in this Territory where occasional cases are apt to be met with. In my experience dur-

ing the past year as a Railroad Surgeon, I have come across a few cases confined to Mexican laborers recently arrived from Mexico, and one case has come under my observation during the three weeks I have been in this Territory.

Porto Rican anaemia is not as was believed a few years ago due to insufficient or improper diet, but it is a specific infectious disease due to infection by the *Uncinaria Americana*, or the New World parasite, and characterized by progressive anaemia, general reduction in strength, various nervous and gastric disturbances, and in severe cases general "drowsy".

I have not found in Porto Rico the Old World variety of the parasite, although reported to be the most common in some parts of the British West Indies (Granada). These two species differ in the size and armature of the mouth; the Old World parasite being larger with a heavily armed mouth containing two pairs of hook-like ventril teeth and one pair of dorsal; the New World variety is smaller, with two pairs of semi-lunar ventril plates or lips, and one dorsal pair.

The worm is seen in the feces and is about half an inch long, resembling a bit of white thread. It lives in the upper part of the small intestines, being fastened between the folds of the mucous membrane by its head; the oral capsule, like a cupping glass, draws a piece of mucous membrane into its cavity and fixes it with its teeth.

The worm has been considered by Stiles and others as a blood sucker. This I am convinced is an error. The amount of blood lost in this way could not be sufficient to produce the marked grade of anaemia seen in Porto Rico. In some of my very pronounced cases only a few of the parasites were found,

not enough to cause any marked loss of blood, and the severe anaemia was in every case cured by expulsion of these few worms. In an examination of the intestinal canals of two hundred worms I found only three to contain blood, and these I believe can be explained on the theory of accidental opening up of some vessel by these worms, the probability of this cannot be denied when we consider the worm as feeding on so vascular a substance as the intestinal mucosa. I found the contents of the intestinal canal to be epithelial cells chiefly, and not red blood cells. Again, if these worms were blood suckers, blood should be found in the stools of the patient. Of 21,403 specimens of feces personally examined, only 12 contained sufficient blood to be detected by a macroscopic inspection, and on microscopic examination only 22 specimens were found to contain red blood cells.

What then is the cause of the pro-found anaemia in *Uncinariasis*? I am thoroughly convinced that there is a toxin produced by the parasite, and that this toxin is the true cause of the anaemia, the headache, dizziness and gastric disorders. A marked eosinophilia, normal red cells, and low hemoglobin at the very beginning of this disease, and the marked nervous symptom and frequent high elevation of temperature all indicate toxemia.

How does the infection by the *Uncinaria* take place? I feel justified, from my observations in Porto Rico, in saying that there is but one mode of infection, and that is through penetration of the skin by the larvae. The disease is primarily a filth disease. The only way of infecting the soil is by emptying the bowels where the eggs in the feces will later develop. Earth-soiling in Porto Rico is very common



everywhere outside of the city. Latrines are unknown in the country districts. Everywhere on the island the laboring people go bare footed, and almost everywhere they may get the parasite into their feet. No place is exempt from contamination for the countryman pollutes the soil anywhere it may be convenient for him to do so, especially under the shade of the coffee tree when he receives a call from Nature while picking coffee or beneath the banana trees which surround his little shack. The ovum cannot develop to maturity in the intestine, but when the feces is deposited on earth in a shady, moist place and exposed to a relatively high temperature, the ova hatch out in 24 hours. The young worm sheds its skin twice and is then ready to infect man.

It gains entrance into the skin of the bare-footed countryman and makes its way by some undetermined route to its place of election in the small intestines.

A dermatitis usually between the toes (where the infected mud has been squeezed in) is the first sign of infection by Uncinariasis. This is the so-called "ground itch", or what the Porto Ricans refer to as "mazamorra". In all cases I made very careful inquiry for this symptom, which I have styled "Uncinarial dermatitis," and the following table shows the result:

Table No. 1—Uncinarial Dermatitis.

Present.	No History.	Per Cent Present.
4956	44	99 plus

In my 5,000 cases 99+ per cent. certainly received their infection through skin penetration. I do not consider infection by the mouth, as claimed by many observers, even a rare possibility. It has been shown that the parasite dies rapidly on drying. In order to get infection by the

mouth, the individual would have to ingest wet mud. Infection by muddy drinking water, as claimed by some authors, I also believe to be an impossibility. One part of solid matter to the thousand has been proven to be fatal to the larvae and water containing a greater portion than this would be too repulsive for even the unclean Porto Rican country man. Six of my cases were well-to-do Americans in whom I had to exclude infection by ingestion of mud or muddy water, and in each case there was a history of uncinarial dermatitis and of exposure from going barefooted.

The observation of Stiles that Uncinariasis "is pre-eminently a disease of sandy localities," does not hold true as regards the disease in Porto Rico. I have studied the condition in every part of the island and I found the foot hills to be the most heavily infected districts, and no part of the island to be free from infection. All kinds of soil, sandy, alluvial and clay, furnish proper culture of larvae if there is present sufficient shade and a relatively high temperature.

Uncinariasis is to be seen in its worst form in Porto Rico. I have had opportunity to observe this disease in Brazil, Panama, Guatamala and Mexico, and have studied the reports of cases seen in Europe and in our own Southern States and in the Philippines, and the so-called "light infections" in Porto Rico would be considered severe cases in other countries where the disease exists.

So marked are the condition in Porto Rico that every stranger visiting the island at once notices the pallor of the country people. This pallor is a fair sign of the amount of anaemia present, but it does not bear a constant relation to the percent of hemoglobin.

The conjunctiva and mucous membrane of the mouth are more reliable guides. The following table will give an idea of the severity of the anaemia in my series of cases:

Table No. 2—Pallor

	Number.	Percentage.
No Pallor .....	176	3.5
Slight Pallor .....	662	13.2
Moderate Pallor ....	986	19.7
Marked Pallor .....	1636	32.7
Extreme Pallor ....	1540	30.8
	5000	

63.5 per cent. showed more than a moderate pallor. The hemoglobin, however, is the best index to the amount of anaemia, and the following table gives the hemoglobin percentage in my cases:

Table No. 3—Hemoglobin Percentage.

	Number.	Percentage.
Below 10 per ct....	3 (8, 8, 9)	
Between 10 and 20..	202	4.1
" 20 and 30..	675	13.5
" 30 and 40..	1326	26.5
" 40 and 50..	1112	22.2
" 50 and 60..	748	14.9
" 60 and 70..	526	10.5
" 70 and 80..	278	5.5
" 80 and 90..	107	2.1
" 90 and 100..	23	.4
	5000	

Average hemoglobin percentage, 44.1 per cent. Do you wonder that the Porto Rican is called lazy and unambitious and that the American press delights in referring to this plague as the "lazy disease," when the blood of nine-tenths of the laboring class is below fifty per cent. of what it should be?

Uncinariasis affects all ages, but the suffering is greatest amongst the young, as the following table will show:

Table No. 4—Age of Patients.

	Number.	Percentage.
Under 5 years .....	42	.8
Between 5 and 10...	284	5.7
" 10 and 20....	1363	27.2

" 20 and 30...	1863	37.2
" 30 and 40...	872	17.2
" 40 and 50...	306	6.0
" 50 and 60...	183	3.6
Above 60 years....	84	1.6

5000

71.4 per cent. under 30 years of age. In childhood the disease causes retarded mental and physical growth. I have seen children of 16 as small as the average child of 8 or 10, and I have seen young men and women of 25 with the development of children of 14 and 15. It results in delayed puberty and anaemic mothers in many instances have never menstruated.

Some investigators state their belief in a degree of immunity possessed by the negro. Some of my most pronounced cases were in negroes, and the following table shows immunity of the toxin exists in the negro to only a slight extent:

Table No. 5—Race Compared with Hemoglobin.

	Whites.	Mullat- toes.	Neg- roes.
Below 10 per ct....	2	1	0
Between 10 and 20..	132	62	8
" 20 and 30..	526	142	7
" 30 and 40..	960	301	65
" 40 and 50..	801	214	97
" 50 and 60..	437	280	31
" 60 and 70..	364	140	22
" 70 and 80..	120	134	24
" 80 and 90..	56	40	11
" 90 and 100..	9	11	3
	3407	1325	278

Average of 41.2 per cent. hemoglobin for white race.

Average of 43.8 per cent hemoglobin for mulatto race.

Average of 47.4 per cent. hemoglobin for negro race.

Two-fifths of the population of Porto Rico is colored, either mulatto or pure negro. Sixty-eight and one-tenth per cent. of my cases were white patients; twenty-six and five-tenths per cent. were mulattoes, and five and four-tenths per cent. negroes.

**DIAGNOSIS OF UNCINARIASIS.**

In every case of anaemia presenting itself from a tropical or sub-tropical country Uncinariasis should be examined for, especially should this be applied regarding Mexican laborers in this Territory. There should be no trouble in diagnosing marked infections from the clinical symptoms alone. The pallor, a dirty yellowish or muddy color, is characteristic; the conjunctiva and mucous membrane of the mouth, and beneath finger nails are the best guides. Digestive disturbances are always present, usually pain in epigastrium and marked increase in appetite. Dizziness and general weakness are always complained of, especially weakness referred to the knees. There are apt to be pains in the chest and bones, often palpitation and perhaps hemic murmur, stupor and lack of memory are pronounced symptoms in the majority of cases. In light and medium cases, and these are the cases seen in this section, it is not best to make a diagnosis on symptoms only. The only reliable method is by microscopical examination of the feces. My method of examining for the ova is as follows:

First: Mix about  $\frac{1}{2}$  oz. of feces in pint of water, and allow this to stand for about five minutes which permits the ova to sink to the bottom.

Second: Pour off the liquid, allowing about 1 oz. to remain in the bottom of glass.

Third: Wash the sediment two or three times.

Fourth: Strain through cheese cloth.

Fifth: Allow settling for five minutes: then draw up small amount from bottom of glass with a medicine dropper. A drop is placed on slide and covered and examined under a  $\frac{2}{3}$  in. objective.

This is the most reliable method and shows the greatest number of ova. The ova are easily recognized. They are of an oval shape averaging 50 microns by 40, and provided with a very thin simply outlined shell which is divided

from the grayish yolk by a zone of clear transparent fluid.

**TREATMENT.**

The disease is easily curable upon removal of the parasite, as the following table shows:

**Table No. 6.**

		Per cent.
Cured ..	4056	81.1
Improved ..	930	18.6
Died ..	14	.3
	<hr/> 5000	<hr/>

Only 2 drugs are worthy of mention in the treatment of this disease. First: Betanaphthol. Second: Thymol.

My first few hundred cases I treated with Thymol, but after some unpleasant experiences with it I tried Betanaphthol, and I must say that I consider it by far the more reliable drug. Thymol is perhaps a more powerful anthelmintic, but the depressant effect of Betanaphthol is not so marked. I treated my cases as follows:

The patient was kept on a liquid diet the day before taking the anthelmintic, and at about 3 p. m. a 1 oz. dose of magnesium sulphate was given in order to thoroughly empty the bowels so that the anthelmintic would act upon an exposed intestinal mucous membrane. The following morning I gave Bethanaphthol, grains 15 (in capsule) at 7, and repeated same dose an hour later, and at 11 a. m. another 1 oz. dose of magnesium sulphate.

I would have patient report to me ten days later, bringing with him a specimen of feces. If ova were still found, the treatment was repeated. The following table shows number of treatments required:

**Table No. 7.**

	Number of Treatments.	Times.
1 treatment .....	126	126
2 treatments .....	389	778
3 " .....	742	2226
4 " .....	1872	7488
5 " .....	1001	5005



6	"	447	2682
7	"	311	2177
8	"	92	736
9	"	16	144
10	"	3	30
11	"	1	11

5000 21403

82 per cent. required from 1 to 5 treatments. My next table shows average number of *Uncinariæ* expelled by successive doses of the anthelmintic in 100 hospital cases.

Table No. 8.

1st treatment	1021
2nd treatment	214
3rd treatment	62
4th treatment	21
5th treatment	11
6th treatment	2

1241

The largest number expelled by first dose, 4,016.

Largest total number (six treatments), 4,872.

The first dose of anthelmintic invariably gives immediate relief from many of the symptoms, and patient always feels better and brighter.

In ten of my hospital cases I tried the formula suggested by Phillips:

	Grams
Eucalyptus oil	2.50
Chloroform	3.50
Castor Oil	40.00

All ten cases suffered from marked dizziness and gastric irritation, and more or less colapse. An average of 428 worms were passed after the first dose. I consider the treatment dangerous and as all my cases rebelled against taking a second dose I discontinued further experiments with this formula. It is, however, the only treatment as far as I know which expels the parasite alive.

#### PELVIC DISEASES OF WOMEN.\*

(By Dr. J. H. Wroth, Albuquerque.)

To endeavor to cover the subject assigned to me—that of Pelvic Diseases of Woman—within the short time al-

lowed me, is an absolute impossibility, almost as much as that of the old nursery rhyme to endeavor to "sweep the cob-webs out of the sky."

I presume that 90 per cent. of the specific troubles of women are due to pelvic troubles of some form and I will hold the axiom that of all pelvic trouble of women at least 90 per cent. comes from one of two things, either a neglected confinement, or an interference with Nature's functions, by an indirect or natural miscarriage.

It is needless in an association of the ability of those present to ask you to go over the anatomy of the female pelvic organs, as it is also needless to suggest to you any question regarding the physiology thereof.

Some few years' experience have convinced me like the little boy in the famous story, that there is one organ connected with the female genitals which succeeds in producing more trouble in proportion to its size and get less blame therefor than any other, in fact, producing almost all the trouble and then subsiding—like the statement of a famous statesman into "inocuous desuetude." I refer more especially to the Fallopian tubes, and this paper I read this evening will be concerned with the problems connected therewith.

From their location and function—it not being necessary to go into detail—they are intimately connected with the uterus at one end and the ovary at the other thereby catching the more important organs as the old ducky says—"gwin' and comin'." While we may dismiss for the moment all particular diseases of either the uterus or ovaries, it is needless to say to those who have had any experience in this matter, that by far the majority of cases—excluding

\* Read before the Bernalillo County Medical Society, March 4th, 1908.

cancer and cysts—have come from an extension of trouble, either forward or backward from primary disease of the tubes themselves.

It is a curious proposition that malformation of the tubes are extremely rare, but it is in their physiological functions that they are prone to acquire pathologic change and unfortunately much more frequent than other organs are prone to disease than their adjacent neighbors. Their capacity for acquiring diseased condition seems to be more marked and more frequent than any other organ in the body. Whether we are believers in the Inspired Word or not we may consider this as the result of the famous incident in the Garden of Eden, the futile search for knowledge, or as part of woman's anatomical development, I leave to more learned psychologists to answer. The fact remains the same.

The diseases of the Fallopian tubes may be considered as either inflammatory, or those of new growth—of which the inflammatory cases are by far the greater. Salpingitis is by far the most numerous of all inflammatory cases and due to various origins. Peritubal inflammation is a condition which only exists as part of a more general peritonitis but which inflammation can be laid in the majority of cases to the tubes themselves as the originating cause. Salpingitis itself may be conveniently divided into hydro-salpinx, hamosalpinx, pyosalpinx, according to the quality of the fluid contained therein. Salpingitis or pure inflammatory pathological condition of the tube should be considered in all cases from its cause provided clinically that cause can be ascertained. Noeggreath claims that all cases of Salpingitis are due to a specific trouble or gonorrhoea. On the contrary Polk

believes endometritis is the most frequent cause of Salpingitis, although he admits that the most distinctive form is that produced by gonorrhoea. Krusen says that salpingitis is never a primary trouble, but secondary to inflammation of the uterus or peritoneum, stating that the inflammation may follow the mucous membrane by direct extension, or may be propagated from the womb through the lymphatic of broad ligament, a proposition I am free to say does not meet entirely with my experience or with anatomical argument. It has been admitted by authors that it may be due to infections or eruptive diseases, which certainly invalidates the argument of direct extension, unless we consider the question of the character of the lining of the membrane of the tube. Uterine malposition, growths affecting the uterus, or narrowing of the os, have all been claimed as causes for tubal inflammation. Exposure to cold, too frequent coition, and too violent exercise before menstruation are considered causative factors of inflammation. Some of the surgical gynaecological treatments of certain character the use of pessaries claimed to be too frequently the cause of tubal inflammation from lack of cleanliness on the part of the operator. The routine practice of introduction of sounds the application of astringents of caustics to the uterine mucous membrane are being often fertile causes of extension of the tubes. Salpingitis itself after being recognizable by the physician is rarely confined to the tube, there is more or less involvement both of the ovary and the uterus.

Modern thought is divided as to the primary cause, although I think the majority of observers are inclined to the theory that, while whatever infec-

tion takes place in the tube must come through the uterus, in the great majority of cases that the location of that infection is primarily in the tube. This of course eliminating puerperal infection. The various organisms that have been identified in tubal affections are the gonococcus, staphylococcus, streptococcus and the tubercular bacilli.

Some thirty years ago it was popular to consider that all cases of inflammatory action were due to the gonococcus, from the teachings of Noegreath, whose ability and persistency impressed their weight upon the profession. It is a question today as to whether his teachings and deductions should be carried to the extent he desired or intimated. In fact other, and as prolific causes, have been found as we more closely study the trouble incident to these organs. Engelmann in a tabulation of over 500 cases among school girls just reaching puberty found that 66 per cent. were afflicted with more or less evidence of tubal congestion and of that 66 per cent. he was satisfied that at least 80 per cent. were free from any suspicion of the gonococcus. Multiplicity of causes that have been attributed to be the cause of inflammatory action of the tubes indicate the uncertainty of causes in the minds of the various observers.

The symptoms of the various grades of inflammatory action are simply those of inflammation elsewhere, modified only by the location and surroundings of the tubes themselves. The nature of the secretion due to inflammatory action is dangerous only from the character of its contents. The swelling usually, and almost always produces closure of the abdominal end of the tube thereby cutting off infection of the peritoneum. Many cases of acute inflammatory action due to

causes not specific undergo resolution and the tubes are restored to their primitive function. The chronic inflammatory condition of the tubes may be secondary to acute but usually are sub-acute or chronic from the beginning, that is, they never present violent symptoms. The results, however, are varied and numerous, the tube becomes enlarged, more tortuous than usual, there being an interstitial inflammation. The enlargement of the tube changes its position and it becomes adherent through direct inflammatory action with adjacent organs. The excursion of the free end of the tube may occur at any point and in any direction and has been found adhering to organs so far distant as to create doubt of the statements made thereon. Fortunately in the large percentage of cases occlusion of the abdominal end of the tube almost always takes place.

Salpingitis has been divided in another direction according to the quality of its contents, whether it contains water, blood or pus. The collection of water, or rather of a thin serous liquid, being more common in catarrhal cases, and pus in more chronic cases, or in acute cases caused by infectious origin. The presence of blood has been agreed to by almost all observers as being synonymous with that of ectopic gestation. Regarding the presence of pus or the condition called pyo-salpingitis, as the disease progresses the organisms causing it become inert and finally disappear.

According to an American observer out of 103 cases the pus was sterile in about 65 per cent.; and according to a German observer out of 116 cases in 72 there were no bacteria at all. And a consensus of all experience goes to show that it is surprising what a quantity of pus may exist in such cases



where there is no evidence from the pulse or temperature to indicate its existence.

As regards symptoms—pain, temperature and tenderness in acute cases are the tripod upon which an opinion may be based. Examination reveals simply a tenderness and a sense of fullness in the region of the tubes. If the patient is thin the enlarged tube may be palpated by the conjoined method. When the disease becomes chronic the symptoms vary and are frequently, if not altogether referred to ovarian disease. Pain is generally continuous but with exacerbation. Dysmenorrhea is frequent. The general health suffers, marked nervous and reflex symptoms develop and sterility is the rule. The history of the patient will aid in diagnosis, but in many cases the chief reliance must be in bi-manual examinations and in many cases under an anesthetic, as only under such conditions can the isolation of the tube from ovarian trouble be made, in fact it is in but a small proportion of cases that pure and simple salpingitis can be diagnosed accurately.

As regards the treatment—prevention by special attention should be directed toward the proper education of the young woman approaching puberty, and no false modesty should be permitted to interfere with advice from the proper source. During menstruation avoidance of exposure and violent exercise; in married women careful attention after labor or abortion, repair of all lacerations which do not heal immediately after labor, and should gonorrhea be suspected immediate and energetic treatment should be carried out, although the suspicion of this rarely can be confirmed until after the damage is done. Gonorrhea and sepsis being the two great causes

of tubal pathological condition; extra precaution should be taken in all cases of intra-uterine exploration, it being remembered that the tube is an open and direct channel between the uterus and the most important serus membrane, the peritoneum.

Should a patient be seen suffering with acute Salpingitis in its earliest stages the treatment is practically the same as that of peritonitis—rest, saline purgatives, hot vaginal douches, generally an antiseptic solution, but which I believe is unnecessary for in these douches heat is the most important factor, it being impossible to reach the focus of infection by any antiseptic introduced in this manner. In some cases much relief will be afforded by ice cold applications over the abdomen. In fact, cold seems to do more good than heat. Elevation of temperature or high tension pulse calls for aconite, if in 48 hours the temperature and pulse rate decrease and the tenderness is subsiding these means should be continued, but if on the contrary they are increased in severity an operation either is, or soon will be demanded, for the purpose of removing the source of infection.

In some cases of acute virulent infection, fatal peritonitis may result in three to four days after the onset. Fortunately in the majority of cases the closure of the abdominal end of the tube prevents extension to the peritoneum, but the tube itself is badly damaged and remains in a condition of chronic catarrhal or purulent salpingitis.

In view of the fact that chronic salpingitis has had time by extension of the tube to involve other organs, treatment differs markedly from that of acute. Whatever involvement of the ovary or uterus have occurred must be

attended to. By some curreting was vaunted to cure the accompanying endometritis. It seems to be mentioned today only to be condemned on account of the danger of producing a recurrence of the acute trouble with all this danger. Hot vaginal injections and tampons with boro-glycerine or ichthyol inserted in the vagina two or three times a week being left in position from 24 to 48 hours with the usual attention to all secretions. It is a question today whether the glycerine in such local methods by extracting water from the tissues is not the real agent giving relief; pelvic massage is recommended by Brandt and in sanitoriums does some good. It is, however, too slow a process for our American patients. It must be remembered that all these methods are purely palliative and that the relief given the menstrual periods and the freedom from pain is but temporary, sooner or later it will have to be repeated. There seems to be no permanent cure for chronic salpingitis short of extirpation, and the sooner this is done the better for the patient especially if there are any growths, lesions, or a distended tube, no matter what its contents may be, or if the length of time has been such as to mat the adjacent organs into one common mass. It is needless here to discuss the operation.

The Vaginal or abdominal route may be selected, and frequently where the patient is very anemic, pulse rapid, with a bulging in the vagina, considerable time may be saved and the safety of the patient better insured by a temporary opening of the tumor in the vagina at its most dependent part, leaving the more severe operation for a more favorable time. In at least four cases I have seen the patient regain health to such an extent that a total removal has never yet been called for.

The various operations done for these cases can be found and described in any surgical work.

I desire simply to call attention to the resection of the Fallopian tube, which has within the past eight years been attracting more than usual notice. It has been proved by Dudley of New York that even when gonorrhoea has been the cause, the resection of the diseased portion of the tube and uniting the extremities, regeneration of the tube has taken place and it has continued its function. Another form of conservative surgery by a German surgeon, whose name has slipped my memory at present, is applied to that class of cases where the abdominal end of the tube has been closed by a former inflammatory action and consists in making a new opening in the tube, or rather a long split in it which is sewed directly over the ovary; in this way retaining in those cases where imperative the child bearing function.

It is needless to say that the success in this operation depends upon careful selection of the case and individual skill. I presume that to all time the majority of operations upon the tubes will be for total removal and in a series of cases published two years ago it was noted that in 95 per cent. the ovary also required removal. As regards the technique this is not the place to speak of it.

Tuberculosis of the tube is said by Kelly & Penrose to be more apt to effect the tube than any other part of the genital organs. According to one writer it is present in 20 per cent. of the cases operated on. According to Williams in one out of every 12 operations this form of infection is present. It is usually secondary and may affect the tube long before puberty. A Boston surgeon has described a case in which a child under five years of age

died of tuberculosis of the lungs and the autopsy showed caseous nodular masses in the tubes. An English physician reports a similar case. By Penrose, tuberculosis of the tubes has been divided into three classes: millary, chronic diffuse, and chronic fibroid. The first is simply the first stage of the disease which may progress no further, or may be transformed into one of the other two varieties. The third form, chronic fibroid, comes slowly and is said to sometimes terminate in a spontaneous cure.

The symptoms of tubal tuberculosis resemble those of salpingitis and are not characteristic. The diagnosis is always obscure and can only be made by the question of heredity or the presence of other signs elsewhere, especially in the lungs, almost all of the cases of tubal tuberculosis have been discovered at operations or autopsies. If such a condition can be even suspected, operation is imperatively called for, and the same results may be expected as when similar operations performed for tubercular peritonitis. New growths of the tubes are rare, except as the result of inflammatory action. Cysts are found in the walls of the tubes. Fibroids are exceedingly rare and usually found so near the walls of the uterus as to create somewhat of a doubt as to their origin. Carcinoma of the tube is usually secondary and generally results in involvement from cancer of the uterus or ovary. It is generally one sided. While these cases are usually secondary some 15 cases of primary cancer have been reported and well authenticated. In nearly every case the cancer was a papilloma. Fatty tumors have been found but rarely.

According to Doran, there is no evidence that the dermoid tumor of the tube has ever been seen.

For all these new growths there is

but one treatment—that is operation, neither can they be differentiated before section as the sole indication would be an indescribable uncertain mass in the tube, the true nature of which can only be ascertained by visual inspection.

There are one or two facts in this connection to which I desire to call your attention. It may be that my experience has been more limited than that of others, or that my diagnostic ability has been at fault, since I am coming more and more to the conclusion that the opinion of Nogregeath that all cases of tubal trouble were of gonorrheal origin has been grossly exaggerated. I believe that there are other equally important and equally successful—if the term may be used—factors in producing tubal infection. Although I am frank to say that I have not yet succeeded in finding any real cause to which I can positively attribute these results. It speaks pretty severely for the honor of our women were we to accept Nogregeath's dictum, especially as we are finding cases where ages and conditions should be considered free from that source of infection. The microscope will give us no aid in this matter as the gonococcus disappears within a short time after the inflammation begins and by action of the very inflammatory products themselves is destroyed. Suffice it to say that only in the tube we find fertile soil for any and all kinds of bacterial growth, that unlike other organs it does not seem to possess the power of resistance that it should have. From its situation it has the unenviable quality of transmitting this infection in two directions; that uterine, ovarian and peritoneal involvements are common sequels, and that except for the mildest cases no treatment is satisfactory save operation; that under our present



knowledge, conservative surgery can be successfully employed if early applied. And on every one of us who is in the habit of making local examinations and inter-uterine applications should rest the feeling of responsibility and knowledge that a careless slip in our technique—done perhaps in haste, or forgetfulness—may convert a comparatively simple trouble into one of the gravest that our patient can endure.

### SCARLET FEVER.

(By R. E. McBride, M. D., Las Cruces, N. M.)

#### Report of Cases.

The cases of scarlet fever reported here occurred among the boarding pupils of the Loretto Academy at Las Cruces.

The oldest patient was 15 years and the youngest 9.

There were no deaths.

The treatment consisted of chloral hydrate in doses of sufficient size to keep the nervous system in abeyance and the patient quiet. Not enough was given to produce even mild hypnosis, the idea being to quiet the nervous system. In addition to the chloral a solution (1%) of protargol was used in the throat three times daily with a swab. These measures were used in addition to the usual treatment employed in such cases. A gargle of the U. S. P. Liq. Antisep. in hot water was used in the throat at frequent intervals while the nasal passages were kept clean with normal salt solution. The skin was kept active by daily sponge baths and an ointment of menthol in lanolin was used where necessary to allay itching and keep the skin soft. The bowels were kept open by salines and colonic flushings after a preliminary calomel purge. The diet was liquid and un-irritating, as much latitude as possible

being allowed. An occasional dose of spirits of nitrous ether was used where a mild diuretic seemed necessary.

#### Case 1.

E. M., aged 15, was first seen on the morning of November 19th and at this time had a temperature of 101 and a pulse 106. The throat was quite sore and the glands about the neck swollen and quite painful. The rash was well marked. The symptoms were easily interpreted, and treatment commenced.

This patient had enlarged tonsils, adenoids and some hypertrophy of the turbinate bones. There was also an eczema of the eye-lids.

The Highest temperature reached was 103° on the afternoon of November 20, the second day, the normal mark being reached on the afternoon of the 26th. On November 29th the temperature rose to 100° after a slight chill (having been normal for three days) and the patient complained of some pain over the left side of the face from the nose out to the ear. The parts were swollen and slightly reddened. In a few hours the swelling had extended quite a bit and the temperature had reached 104°. A complicating erysipelas was recognized. This condition was met by brisk purgation and local applications of an ointment of iodine and ichthyol over which was placed an ice bag. The next morning the temperature had declined to 101°, and although the swelling was as marked, the redness had not made any further gain. By afternoon of the same day the redness, pain and swelling had manifested themselves on the opposite side of the face and the temperature was again 104°. The same treatment was applied as had been applied to the left side and the next morning (Dec. 1st) the morning tem-

perature was  $99\frac{4}{5}^{\circ}$ . There was no further extension of the condition and the normal temperature was reached on December 3rd. A progressive convalescence followed.

In this case, despite the complication, the urine showed no albumin although great care was taken in the examinations. There was no evidence of any heart weakness although after results showed that the disease left its impress upon the heart muscle for in January this patient developed la grippe which rapidly ran into a consolidated lung and a well marked case of lobar pneumonia with death on the fifth day. So far as the skin lesions in the scarlet fever are concerned, there was practically no itching and desquamation was rapid and complete.

#### Case 2.

D. B., aged 12, when first seen had been ill for two days and presented the usual symptoms of a mild case of scarlet fever with a marked rash, sore throat and enlarged glands about the neck. The tongue was a typical scarlet fever tongue. The temperature at this time was  $103^{\circ}$  (Nov. 21st) and the pulse 110. Treatment was begun as outlined above, the temperature reaching normal November 26th, at no time being higher than when the patient was first seen.

The urine was clear throughout the attack and remained so for a month afterward when the child passed from my observation. There were no complications. There was little or no itching during the attack and desquamation was rapid and complete.

#### Case 3.

A. K., aged 12, was first seen November 23rd at which time the temperature was  $102\frac{1}{5}^{\circ}$  and the symptoms were apparently those of a mild case. The initial temperature was

the highest reached during the course of the disease, while the normal was reached November 27th. There were no complications and the aftercourse of the disease was the same as in case 2.

#### Case 4.

K. O'B. was first seen November 23rd at which time the temperature was  $103^{\circ}$ . The rash was profuse and the throat very sore. The picture presented gave every reason to expect a severe attack. Temperature reached normal Nov. 30. During the course of the disease itching was very marked and disagreeable. The desquamation was slow and excessive. This little patient was not released from quarantine until the first week in January. There were no complications, however, and the urine failed to show any albumin after repeated examinations. This case seemed to run the course usual in all scarlet fever cases and treatment did not seem to make any impression upon it.

#### Case 5.

L. P., aged 10, was first seen November 25th. Her temperature at this time was  $100^{\circ}$ , reached  $102\frac{2}{5}^{\circ}$  on the evening of November 26th. This was the highest temperature recorded in this case. The onset was mild and the course of the disease equally so, a normal temperature being reached December 26th in the afternoon. There were no complications and the urine was clear throughout the course of the disease. Desquamation was rapid and not well marked.

#### Case 6.

C. M., aged 9, was first seen December 5th. The onset was mild with a temperature of  $102\frac{2}{5}^{\circ}$ , the highest recorded in this case. A normal was reached on December 11. There were no complications. No albumin in the

urine and no itching. Desquamation was slight and very rapid.

**Case 7.**

C. McE., aged about 9, was first seen December 8th at which time the temperature was  $100\frac{1}{5}^{\circ}$ . The symptoms were those of an ordinary case of scarlet fever. The highest temperature recorded in this case was  $105\frac{2}{5}^{\circ}$  on the afternoon of the first day. This case followed the usual run of the others the temperature reaching normal December 10th in the afternoon. Save for a slight rise in the afternoon of December 13th (due to inactivity of the bowels) there were no complications. The urine was normal throughout. Desquamation was rapid and rather slight.

While the writer is willing to admit that all of these cases presented symptoms that marked them as of the milder forms of scarlet fever, there are several items of interest presented by a study of the records. In the first place there was a relatively short duration of the temperature symptoms as well as an early appearance of desquamation which in six of the cases was entirely of the branny type while in the seventh, the only case that presented any itching (and that severe), the skin peeled in large patches and the process was delayed for several weeks.

The throat symptoms were well marked at the onset, but in no case was there any exudate and at no time did the throat symptoms give any worry. There were no complications involving the ears nor any involving the nasal cavity save the mention made in case 1 of the complicating erysipelas and this patient had enlarged tonsils, adenoids in the posterior naso-pharynx as well as hypertrophic rhinitis so that a complication here would have been expected in even the mildest type of the disease. It is interesting to note

the after-history of this girl and the rapid death which followed a lobar pneumonia two months after dismissal as a scarlet fever patient.

Nothing abnormal was noted in the cardiac apparatus in any of the cases and the kidneys seemed normal throughout the course of the disease and up to the writing of this paper in those cases where examination has been possible. At no time was there even a trace of albumin in any one of the cases, daily examinations being made to determine.

It is not the intention of the writer to make any claims for the treatment followed. It is outlined here for what it is worth. The results might have been the same under any other method of treatment but should the occasion present itself again I feel that I would be justified in resorting to the use of chloral. There was an entire lack of those nervous symptoms that give the physician so much trouble in this class of cases and each night brought a good sleep and a better condition in the morning.

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**REPORT OF SPECIAL HEALTH OFFICER.**

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(By B. Ruppe, President New Mexico Board of Pharmacy and Special Health Officer, Albuquerque, N. M.)

March 3rd, 1908.

To the Honorable Board of Health and Board of Pharmacy of New Mexico.

Gentlemen:—I respectfully beg leave to report that I have visited the following cities, Estancia, Willard, Vaughn, Melrose, Clovis, Texico, Portales, Roswell, and Carlsbad, and on the Rock Island, Tucumcari, Nara Visa, and on the Dawson Branch, Solano and Roy. On behalf of the Board of Health, I filed complaints against P. W. Cate of



Solano, J. D. McClure of Nara Visa, Dr. A. Beauchamp of Nara Visa, and Dr. T. J. Webb of Texico. I found at least fifteen more who are not qualified to practice, but who are so far away from the railroad that it would take considerable time to hunt up sufficient evidence to successfully prosecute. They do not advertise nor put a sign at their place of residence, and consequently it would undoubtedly take an immense amount of time and expense to substantiate prosecution. I was considerably handicapped by not being able to carry with me a list of registered practitioners of New Mexico, but I am glad to say that the Secretary of the Board of Health, Dr. Massie, is working on the record and expects shortly to have a complete list of the registered physicians for publication. I find that the health officers, I mean those appointed for each county, are not in a position to be of much service to me in giving me information as to violators. I therefore must inquire from the druggists who are practitioners, and as under the Pharmacy law I have the authority to examine all prescription files, it is an easy matter for me to locate physicians in the towns and cities, but those districts lying twelve to twenty-five miles from a railroad are the ones at present I am unable to reach. The penalties for violation of the Medical law, are inadequate, and the law is badly worded as it allows a justice of the peace to assess a fine anywhere from one to a hundred dollars. One-half of said fine goes to the school district, or rather, county school fund, and the other half inures to the expense fund of the Board of Health. The Pharmacy law makes the lowest fine one hundred dollars, and all of it inures to the expense fund of said Board. I cannot see how you can successfully meet your expenses if you are relying

on the fines procurable for the prosecution of violators and the upholding of the law. I am satisfied that justices of the peace should have jurisdiction in these cases, but your law should be changed to read that a fine of not less than seventy-five nor more than one hundred dollars for each and every offense. Every day the violator keeps on practicing should be made a separate offense, and all fines collected under this act should inure to the expense fund of the Board of Health. If you run your fine over one hundred dollars, a justice of the peace could only investigate the matter as a committing magistrate. This would give a good many an opportunity of coming into New Mexico, practicing for a month or two, bleeding the people as much as they could, and then decamp for new pastures. I have taken the liberty of recommending to the physicians the formation of county medical societies which would be of vast assistance to the Board in regulating the practice of medicine. Physicians, generally speaking, do not like to accuse or testify against another physician, but all complaints could be brought before the county association, and it could be made the duty of the secretary to immediately send such complaints to the Board of Health. The problem of sewerage in these new towns, especially those situated on the prairie, is going to be quite a problem. I found Texico especially in a very filthy condition, outhouses in a terrible state, and I believe that the Board of Health should take the matter in hand and see that something is done to place these towns on a sanitary basis. The same condition as exists in Texico is also notable in the other towns, and while there is a disposition on the part of a good many to remedy this, nevertheless the towns not being incorporated no con-

certed movement has been inaugurated. If pits are to be used, or as the Government designates them, sinks, they should at least once a week be sprinkled with chloride of lime and covered with fresh earth, and where the box system is used, once a week at least it should be thoroughly cleaned and disinfected. I also take the liberty of suggesting that every county health officer should be entitled to one deputy at every town, and for example I will quote you Roosevelt county. There are, as far as I could learn, fifteen towns ranging from one to five thousand in population, and you have but one county health officer. In case of any epidemic or other necessary investigation under the health officer's supervision, he would be obliged to detail some physician to assist him, as it could not be expected that he would go to some other town and take personal charge to the detriment of his practice and his own personal affairs. Dr. White, the health officer at Portales, has all the work he can possibly do with his practice and drug store, but nevertheless he is willing to perform his duty, but it looks to me as asking too much for one man to look after such a vast amount of country and keep in touch with everything appertaining with his office. Therefore, he should be allowed a deputy, for instance, at Texico, Clovis, Melrose, and any other town having over one thousand population. On behalf of the Board of Pharmacy, J. L. Nickolay at Solano, Joe Murphy at Nara Visa, M. Kennedy at Clovis, J. McNeely at Texico, J. B. Woodward at Melrose, Pierce and Dobbs at Portales and F. J. Johnson at Texico, were all fined in the sum of one hundred dollars, except in the case of Mr. Murphy who also had an unregistered clerk, whose fine was two hundred dollars. These cases brought the Board

of Pharmacy eight hundred dollars, while the four violations of the Medical law produced but seventy-five dollars towards the fund of expenses.

The eastern part of New Mexico has grown so phenomenally, and being so close to the Texas border, has made it possible for practitioners of Texas to also practice in New Mexico. The grand jury will meet in the month of April at Portales and later at Roswell, and I have several cases which the District Attorney will assist me in, as I can get better results in the district court than I can in the court of the justice of the peace, the only difference being, as I stated in the fore part of my report, the possibility of the illegal practitioners leaving the country before the convening of the district court. Necessity requiring my attention at Albuquerque on personal business, I laid off for a few days, but expect to be out on the road again in a short time and make a more satisfactory report to the Board.

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#### A PLEA FOR REASONABLE HARMONY IN MEDICAL THERAPEUTICS.

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(By George K. Angle, A. M., M. D., Silver City, N. M.)

Reading through the standard works on the practice of medicine one is especially struck with the different clinical pictures and treatment of the more common and well known diseases, and those of us who have a real yearning for the truth in regard to things medical, perhaps are pained to note not only the latitude in therapeutics amounting to most any and every drug in the pharmacopoea, but also many absolute contradictions in regard to the use of certain specific drugs and procedures under practically the same conditions.

Is it not a reflection and discredit to

the science of medicine that even at this date the science can not be agreed as to whether it is correct to give a saline in the early stages of acute appendicitis, whether it is correct to use opiates or no, whether heat or cold locally or neither should be applied; granting the availability of a good surgeon even then interference by the knife may be a question of doubtful propriety.

Passing from the common and fashionable appendicitis we will consider that old familiar disease pneumonia. Surely here after a century of intimate acquaintance the science should have evolved something more definite in its treatment, but not so. Perhaps in this disease medical science shows even more hesitancy than in any other.

Is it worth the while to give a large initial dose of quinine and morphia? Shall we use the veratrum or aconite or shall we bleed? Should we apply ice or poultice or neither?

Stage second. Shall we sustain the heart by digitalis and strychnia or shall we give nitroglycerin and remove part of its load? Is or is not alcohol of any utility at any time or under any or all conditions? Are expectorants good drugs to use or are they positively harmful? Is it correct to remove our patients to the house tops or out on the porches to give them an abundance of pure, cool air? Is it worth the while to counter irritate to clear up a dull patch or is it better to encourage circulation through it by increasing the blood pressure? Is it worth the while to give a so-called bowel antiseptic in enteric fever or is it all nonsense? Shall we treat influenza with quinine or is it to be tabooed as a drug which does positive harm? Shall we give drugs in the early cardiac lesion or advise the gen-

tle life reserving drugs for the later days of failing compensation? Shall we stay the drenching sweats of mixed infection in tuberculosis or shall we say no, never, sweating is a good thing, it eliminates poison and thereby heart muscle is conserved.

Is it proper to give croton oil in cerebral hemorrhage or is it harmful?

The questions I have propounded you may find answered both yes and no, and some will say rightly so, nevertheless waiving the fact that disease should be treated according to conditions found at the time, it is contended that under practically the same conditions you will find one authority saying certainly yes, and another certainly no.

Now, the truth must be either one or the other and we privates in the profession want to know which. Let the acknowledged leaders in medical science hold a sort of an oecumenical council as it were; go there with a firm resolve to ascertain the truth so far as the present state of medical knowledge will permit. Let them come to a reasonable harmony in therapeutic technique and have the same published as the standard text book on the practice of medicine. When this way of disposing of the question obtains it will not be necessary for the professor of medicine in every medical college to publish a text book of his own lest his college lose prestige or sadder still, that he should play his part on the stage unnoticed and die unhonored and unsung. And so, also, it may give us a rest from the everlasting and never ending dissertations upon diseases which now fill our medical journals *ad nauseam*, each one different from the other and as often absolutely contradicting each other till medical thought becomes a perfect chaos and its representatives a scien-



tific mob, having no fixed truth, having lost the faith and like a ship without a rudder tossed here and there by every wind that blows. Let those who occupy the seats of the mighty get together and we in the local and county medical societies will accept their dictum as our creed.

When this question is once settled there shall be no longer that searching after something to relieve every trifling symptom. The decree of the council will make medicine more of a science and less of an art, and the fraternity will learn to tell sick people how they are and not ask that question of them; they will then feel that they are part and parcel of a great body of truly scientific men and with an eye fixed on certain elemental and on unchanging truths they will go forward in harmony to the benefit of humanity and the glory of the profession.

#### AN UNUSUAL HYSTERECTOMY.

(By Howard Crutcher, M. D., formerly Surgeon to the Chicago Baptist Hospital; formerly Instructor of Surgery in the University of Illinois; formerly Consulting Surgeon to the Chicago & Alton Railroad.

M. K., aged 33, never married, a housemaid in the family of Dr. C. L. Parsons, of Roswell, had been a sufferer for several years from an incurable prolapsus and retroflexion. The symptoms, local and reflex, were numerous and gave the patient great distress most of the time. The situation being explained to her by myself and others, she chose hysterectomy as offering to her the surest means of a permanent cure.

After proper preparation, the operation was performed by Dr. D. H. Galloway and myself on December 18, 1907, under ether anesthesia administered by Dr. J. C. Nichols. The oper-

ators intended at the outset to perform a vaginal hysterectomy, with the use of clamps, but finding the peritoneum extremely thick and highly elastic, we removed the uterus entire by bloodless dissection, without opening the peritoneal cavity at any point save where the Fallopian tubes enter the uterus. No ligatures or clamps were necessary in the operation. The peritoneal envelope was packed tightly with iodoform gauze, no stitches being applied to the severed vaginal mucous membrane. Considerable oozing followed the operation, but no complications whatever arose and a week later the patient walked to the dining room and ate a Christmas dinner. Her mental and physical improvement have been decided since the date of the operation.

My recollection is that the operation, as performed by us, was first performed by Von Langenbeck about the year 1822. Langenbeck's claims were bitterly disputed at the time, but he was able subsequently to demonstrate the genuineness of his claims by a post-mortem examination. The conditions which render a Langenbeck operation possible are necessarily very rare. I performed the operation six years ago at Wesley Hospital, Chicago, upon Mrs. S., but have failed many times to enucleate the uterus, without rupturing its peritoneal covering.

I do not believe that the Langenbeck operation possesses any special merit over the straight forward clamp operation, which may be done more speedily and with just as good practical results.

During our residence in Chicago, Dr. Galloway and I performed a number of vaginal hysterectomies, always employing the clamp method, and without a death. In one case, the woman, a supposed opium eater, bled

profusely, but made a perfect recovery. In a large number of these operations, I have never stitched the divided surfaces, simply using gauze packing, and have no death to report. It must be remembered that the area in unavoidably infected, there being no human means of rendering it sterile, and I seriously question the wisdom in any case of closing the peritoneum after a vaginal hysterectomy.

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**A NEW METHOD OF TESTING THE  
FUNCTIONS OF THE DIGESTIVE  
APPARATUS.**

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Einhorn (Therapeutic Gazette, January, 1908) submits a method for investigating the functions of the intestinal tract, the principle of which is the administration of test substances with the food and observation of the effects of the digestive fluids upon these substances.

Practically this test is made as follows: Patients are given in a gelatin capsule a string of beads with the following substances attached thereto: catgut, fish-bone, meat, thymus, potato, mutton fat. After administering the capsule, every stool is examined with the stool-sieve until the bead-string has been recovered. If diarrhea is present the sifting may not be necessary, as the bead-string can readily be seen (usually at the bottom of a glass vessel).

Under normal conditions the bead-string appears after one or two days. It is then rinsed in cold water and examined. If digestion is normal we find that catgut, meat, and potato (except the skin) disappear entirely, thymus and fat almost entirely, whereas the fish-bone usually disappears, but occasionally it may be present. The nuclei of the thymus always disappear. In pathological conditions deviations from the normal are observed, not

only in regard to the time of recovery of the beads (disturbances of motility), but also in regard to the presence of the food substances (disturbances of the digestive function).

The author divides his cases of intestinal digestive disturbance into two groups: 1. Those of pure nervous intestinal dyspepsia. 2. Those of genuine intestinal dyspepsia.

In that great class of cases of intestinal dyspepsia, in which the starch digestion alone is disturbed, Taka-Diastase (Takamine) has proved of especial value.

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The president of the New Mexico Medical Society was invited to attend the meeting of the Missouri Valley Medical Society that is to be held in Lincoln, Neb., March 19th and 20th, and to read a paper. At first it was thought that the invitation could be accepted, but a rush of work as well as other matters, has prevented the acceptance of the invitation. It is desired to express the appreciation of the New Mexico Medical Society for the honor conferred and it is deeply regretted that it was impossible to be with the Missouri Valley Medical Society at their annual meeting.

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**THE HODGKINS FUND PRIZE OF \$1,500**

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Is Offered by the Smithsonian Institute,  
Washington, D. C., in Accordance With  
the Following Announcement:

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In October, 1891, Thomas George Hodgkins, Esquire, of Setauket, New York, made a donation to the Smithsonian Institution, the income from a part of which was to be devoted to "the increase and diffusion of more exact knowledge in regard to the nature and properties of atmospheric air in connection with the welfare of man."

In the furtherance of the donor's wishes, the Smithsonian Institution has from time to time offered prizes, awarded medals, made grants for investigations, and issued publications.

In connection with the approaching International Congress on Tuberculosis, which will be held in Washington, September 21 to October 12, 1908, a prize of \$1,500.00 is offered for the best treatise that may be submitted to that Congress "On the Relation of Atmospheric Air to Tuberculosis."

The treatise may be written in English, French, German, Spanish or Italian. They will be examined and the prize awarded by a Committee appointed by the Secretary of the Smithsonian Institution in conjunction with the officers of the International Congress on Tuberculosis.

The right is reserved to award no prize if in the judgment of the Committee no contribution is offered of sufficient merit to warrant such action.

The Smithsonian Institution reserves the right to publish the treatise to which the prize is awarded.

Further information, if desired by persons intending to become competitors, will be furnished on application.

CHARLES D. WALCOTT,

Sec'y. Smithsonian Institution.

Washington, Feb. 3, 1908.

#### MANY DOCTORS SECURE LICENSES.

Santa Fe, N. M., Jan. 15.—The meeting of the Territorial Board of Health which re-convened here yesterday was almost exclusively devoted to considering the qualifications of applicants to practice medicine in New Mexico.

During the sessions licenses were granted to thirteen physicians who have been practicing their profession for a number of years and possessed certificates issued by various states.

Only three applicants were required to take the examination because of not having practiced the necessary length of time after graduation.

Nearly all of the applicants were recent arrivals in New Mexico. The following physicians were admitted upon their credentials:

Dr. G. H. Burnham, of San Juan; Dr. Margaret Cartwright, of Albuquerque; Dr. Henry O. Conaway, of Farmington; Dr. Henry Gray, Aztec; Dr. Chas. C. Hendrick, Albuquerque; Dr. Joseph P. Jones, of Carlsbad; Dr. Andrew W. Moore, Stanley; Dr. Daniel R. McCormick, of Albuquerque; Dr. Marcellus McCreary, of Magdalena; Dr. Betrand M. Potter, of Melrose; Dr. George W. Sammons, of Farmington; Dr. William P. Schelly, of Hagerman; Dr. J. Scott Ward, of Albuquerque.

Thomas B. Fischer, of Santa Fe, C. F. French, of Albuquerque, and H. J. McClement, of Alamogordo, were given licenses as embalmers and funeral directors.

#### NEW MEDICAL COLLEGE AT MANILA.

Announcement is made that the new medical college of the University of Manila will be opened early in September. Especial attention will be paid, it is said, to tropical diseases. The Philippine Government has appropriated \$62,500 for the expenses of the first year of the institution.

#### BOOK REVIEW.

##### MINOR SURGERY.

(By Edward Milton Foote, A. M., M. D., Instructor in Surgery, College of Physicians and Surgeons. (Columbia University); Lecturer on Surgery, New York Polyclinic Medical School; Visiting Surgeon, New York City Hospital; Visiting Surgeon, St. Joseph's Hospital; Consulting Surgeon, Randall's Island Hospitals and Schools. Formerly Chief in Surgery at the Vanderbilt Clinic.)



Illustrated by four hundred and seven engravings from original drawings and photographs.

8vo.; price, cloth, \$5.00 net. D. Appleton & Company, publishers, New York.

Many excellent text-books on Surgery have appeared during the last few years in two, three and four volumes, in which the more serious surgical conditions are exhaustively discussed, while "Minor Surgery," which forms the bulk of surgical practice for the average man is condensed into a chapter or two.

This volume fills a long-felt want, for it describes in detail the numberless little accidents and surgical diseases which the general practitioner is called upon to treat.

The value of the work is greatly enhanced by the great number of photo engravings, every section being well illustrated.

A list of contents follows:

Section 1—Affections of the Head.

Section 2—Affections of the Neck.

Section 3—Affections of the Trunk.

Section 4—Affections of the Genito-Urinary Organs.

Section 5—Affections of the Anus and Rectum.

Section 6—Affections of the Arm and Hand.

Section 7—Affections of the Leg and Foot.

Section 8—Minor Surgical Technique.

Section 9—Bandaging.

Section 10—Surgical Dressings.

#### DISEASES OF THE NERVOUS SYSTEM.

(Edited by Archibald Church, M. D.; Professor of Nervous and Mental Diseases and Medical Jurisprudence, Northwestern University, Medical Department, Chicago, Ill.)

(An Authorized Translation from "Die Deutsche Klinik," under the general editorial supervision of Julius L. Salinger, M. D.)

This volume is the fourth in the series of Appleton's "Modern Clinical Medicine," the first volume of which was on "Infectious Diseases," edited by Dr. James C. Wilson, Philadelphia; the second, "Diseases of Metabolism and of the Blood, Animal Parasites, Toxicology," edited by Dr. Richard C. Cabot, Boston; and the third, "Diseases of the Digestive System," edited by Dr. Frank Billings, Chicago.

A most favorable reception has been given these preceding volumes and as the fourth is of the same standard and upon a most important subject we can only predict for it the same favorable consideration.

There are many books covering certain phases of Nervous Diseases, but this volume takes up the subject in its entirety with a

completeness that can be found in no other one-volume work published in this country.

A list of contents follows:

Neuralgia, by H. Eichhorst, Zurich.

Paralysis Agitans, by W. Erb, Heidelberg.

Headache and Migraine, by L. Edinger, Frankfurt-on-Main.

Hemorrhage of the Brain and Embolism, by R. Geigel, Wurzburg.

Disturbances of Speech, by H. Gutzmann, Berlin W.

Sexual Neurasthenia, by A. Eulenburg, Berlin.

Normal and Pathological Histology of the Central Nervous System, by H. Rosin, Berlin.

Anatomy of the Central Nervous System, by H. Rothmann, Berlin W.

Lumbar Puncture, by H. Quincke, Kiel.

Syringomyelia, by F. H. Schultze, Bonn a. Rh.

The Aphasic Symptom-Complexus, by C. Wernicke, Breslau.

Multiple Sklerosis, Spinal Paralysis, by E. Redlich, Vienna.

The Examination of Sufferers from Nervous Diseases, by P. Schuster, Berlin.

Diseases of the Brain, by E. Redlich, Vienna.

Athetosis, by L. V. Frankl-Hochwart, Vienna.

Vasomotoric, Trophic, and Secretoric Neurosis, by R. Cassirer, Berlin.

Pasedow's Disease, by A. Eulenburg, Berlin.

Thomson's Disease, by L. V. Frankl-Hochwart, Vienna.

Localized Cramps, by E. Remak, Berlin.

Tabes Dorsalis, by W. Erb, Heidelberg.

Tetanus of Adults, by L. V. Frankl-Hochwart, Vienna.

New Formations of the Spinal Marrow, by F. H. Schultze, Bonn a. Rh.

Traumatic Neurosis, by P. Schuster, Berlin.

Progressive Atrophy of the Muscles, by F. H. Schultze, Bonn a. Rh.

Myelitis, by E. V. Leyden, Berlin.

Hereditary Ataxia, by H. Luthje, Erlangen.

Epilepsy, by W. Vorkastner, Berlin.

Hysteria, by T. H. Ziehen, Berlin.

Neurosis of Occupation, by R. Cassirer, Berlin.

Diseases of the Peripheral Nerves, by M. Bernhardt, Berlin.

A glance at the list of contributors is convincing that all are men of international reputation, and your reviewer wishes to assure you that each has vied with the other to make his particular subject the most prominent work in the volume.

The work has one hundred and ninety-five illustrations in the text and five colored plates.

D. Appleton & Company, publishers, New York and London.

8vo.; per volume, cloth, \$7.00 net.

### **COSMETIC SURGERY. THE CORRECTION OF FEATURAL IMPERFECTIONS.**

(By Charles Miller, M. D.)

Including the description of a variety of operations. Unrepaid, \$1.50. Published by the author, 70 State street, Chicago.

Attention is drawn to the fact that there is an increasing demand for surgical measures for the correction of featural imperfections and that the surgeon should keep this fact in mind, not allowing the work to fall into the hands of irregulars whose lack of technic and experience is apt to prove disastrous.

Some of the procedures described in the book are for such deformities as undoubtedly call for treatment, while many apply to modifications which may not be necessary for a patient's health but often demanded for self-satisfaction and happiness.

The book is well illustrated and would prove a worthy addition to the library of any surgeon.

### **OBSTETRICS: A TEXT-BOOK FOR STUDENTS AND PRACTITIONERS.**

(By J. Whitridge Williams, M. D.; Professor of Obstetrics in Johns Hopkin's University.)

Second edition, octavo, 950 pages, 166 illustrations and 16 plates; cloth. \$5.00. Published by D. Appleton & Company, New York, 1907.

Four years ago the first edition of William's Obstetrics appeared and the large sale which followed proved beyond doubt the merits of this great work.

The second edition of this masterpiece is a worthy successor and has been brought up-to-date by entirely new chapters on the "Toxemias of Pregnancy," and "The Development of the Ovary." New matter relative to "Vaginal Cesarean Section," "Pubiotomy," and "Contractions of the Pelvic Outlet" has been added.

The chapter upon "Toxemias of Pregnancy" is alone well worth the price of the entire volume.

The work throughout is logical, well written, well illustrated, and has our endorsement as being the leading treatise upon this subject published today.

### **TRAINING IN MEDICAL ORGANIZATION**

The students of the University of

Pennsylvania Medical School have formed an organization the purpose of which is to acquaint the undergraduates with the workings of the American Medical Association, after which it is very closely modeled. The various student societies take the place of the state organizations and elect members to a House of Delegates which transacts all the business of the association. An annual meeting is held at which papers are read by chosen members thus encouraging original research and a scientific spirit. The organization is named The Undergraduate Medical Association of the University of Pennsylvania and already has over two hundred and fifty members.

### **MEDICAL COMMANDMENTS.**

1. Thou shalt not say evil of thy colleagues nor hurt their business.
  2. Thou shalt treat thy patients, and not experiment upon them.
  3. Thou shalt keep clean thy nails and use much soap and water.
  4. Thou shalt be honest to thy patients and not overcharge them.
  5. Thou shalt not call every belly-ache a case of appendicitis.
  6. Thou shalt not worship in saloons nor seek thy friends there.
  7. Thou shalt not find bacteria everywhere and in anything.
  8. Thou shalt be antiseptic in thy conduct and aseptic in thy practice.
- These were clipped from the Amer. Jour. of Dermatology.

### **ANATOMICAL ACCIDENTS.**

He kissed her passionately upon her reappearance.—Jefferson Souvenir.

She whipped him upon his return.—Burlington Hawkeye.

He kissed her back.—Atlanta Constitution.

She seated herself upon his entering.  
—Albia Democrat.

We though she sat down upon her  
being asked.—Saturday Gossip.

She fainted upon his departure.—  
Lynch Union.

He kicked the tramp upon his sitting  
down.—American Pharmacist.

We feel compelled to refer to the  
poor old woman who was shot in the  
oil regions.—Medical World.

And why not drop a tear for the  
man who was fatally stabbed in the  
rotunda, and who was kicked on the  
highway.—Medical Age.

Why not mention the fact of the  
woman being shot in the water-works?  
—Col. Medical Journal.

How about the woman who was  
hurt in the fracas?—Railway Age.

Or the man who got shot in the gun  
store?—Medical Brief.

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#### The Petroleum Idea.

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An old South Carolina darky was  
sent to the city hospital.

Upon his arrival he was placed in  
the ward and one of the nurses put a  
thermometer in his mouth to take his  
temperature. Presently, when the doc-  
tor made his rounds, he said:

"Well, my man, how do you feel?"

"I feels right tol'ble, sar."

"Have you had anything to eat?"

"Yassar."

"What did you have?"

"A lady done gimme a piece of glass  
ter suck, sar."

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#### Professional Ethics.

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"You'll have to send for another  
doctor," said the one who had been  
called, after a glance at the patient.

"Am I so sick as that?" gasped the  
sufferer.

"I don't know just how sick you  
are," replied the man of medicine, "but  
I know you're the lawyer who cross-

examined me when I appeared as an  
expert witness. My conscience won't  
let me kill you, and I'll be hanged if I  
want to cure you. Good-day."—Phil-  
adelphia Ledger.

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#### APHORISMS.

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Look—(before you prescribe Lache-  
sis) at the neck of a patient who com-  
plains that he cannot bear a tight col-  
lar—you may see a *goitre*.

Look—into the eyes of a patient  
who complains of motes disturbing his  
vision—you may see a beginning *cata-  
ract*.

Look—into the nose of a patient  
who says he has chronic catarrh—you  
may see a *polypus* or *hypertrophied  
turbinate*.

Look—into the rectum when a pa-  
tient (especially a middle aged or old  
patient) complains of frequent at-  
tacks of diarrhoea, sense of fullness  
and straining at stool—you may see a  
*cancer*.

Look—into the rectum of a patient  
who is passing mucus and blood per  
anum—you may see a *polypus*.

Look—into the rectum of a patient  
who says he has haemorrhoids or pro-  
lapsus of the rectum—you may see a  
*cancer* or a *polypus*.

Look—at the inguinal or femoral  
regions of a patient who says he or she  
has swollen glands in the groin—you  
may see a *hernia*.

Look—into the ears of a patient  
who tells you he has catarrhal deaf-  
ness—you may see a *polypus*, a *plug of  
wax* or a long forgotten *foreign body*.

Look—into the vagina of a patient



who complains of profuse or irregular menstruation—you may see a *cancer* of the *cervix*.

Look—into the urethra of a patient who complains of frequent or painful urination—you may see a *caruncle*.

Look—at the feet of a patient who says that six doctors have diagnosed “rheumatism of his feet”—you may see a *flat-foot*.

Look—at the spine of a child who is round shouldered—you may see a *curvature*.

Look—at the prepuce of a boy whose mother complains bitterly of his nocturnal enuresis—you may see a *phimosis*.

Look—into the nose of a child who does not keep up with other children of his age at school—you may see that he is air-starved from *adenoids*.

Look—into the mouth of a patient who says he has a “torpid liver”—you may see some *carious teeth*.

—Y.

Wild-eyed Man — I want some soothing syrup, quick.

Druggist—What sized bottle?

Wild-eyed Man—Bottle? I want a cask. It's twins.—Illustrated Bits.

First Doctor—Was the operation successful?

Second Doctor—Splendid! We located the trouble just where I said we would, but we had to cut nearly through the man to find it.

First Doctor—Will he get well?

Second Doctor—The patient? Bless

you, no! He died directly after we begun.—Judge.

“Methuselah,” asked a dear friend, “how do you account for your extraordinary longevity?”

“It is very simple,” Methuselah answered. “I married a good cook.”—St. Louis Dispatch.

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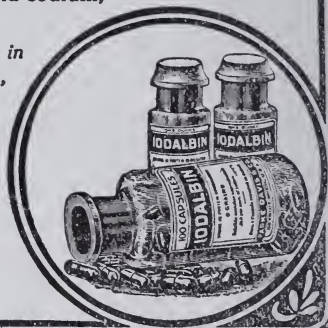
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**CONTENTS**

Editorial .....	3
Vaginal Hysterectomy, Dr. S. D. Swope .....	4
Ophthalmia Neonatorum, Dr. W. G. Shadrach .....	8
Report of Special Health Officer, B. Ruppe .....	9
Vaginal Hysterectomy in a Pregnant Woman — Recovery, Dr. Howard Crutcher .....	10
Sleeplessness, Dr. John W. Colbert.....	11
Surgery of the Gall Bladder, Dr. D. H. Carns .....	15
How I Came to Originate Osteopathy, Andrew T. Still .....	22
Miscellaneous .....	26

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**EDITORIAL****OUR NEXT MEETING.**

The next annual meeting of the New Mexico Medical Society will be held in Albuquerque, Wednesday and Thursday, September 2nd and 3rd. The secretary desires that these dates should be kept in mind and would urge all members to be present.

The Committee on Arrangements and the entire membership of the Bernalillo County Society is taking an active interest and purpose making this meeting the best attended and most instructive yet held, and a surprise in the way of entertainment for visitors is promised.

The scientific section of the meet-

ing will be given much thought and many papers of great worth are promised. The secretary would request all members who intend presenting papers to send in the title as soon as possible in order that the program may be properly arranged.

Please remember that the New Mexico Medical Society is the only door to membership in the American Medical Association for physicians in the Territory; every regular physician in the Territory ought to join us. Application blanks will be gladly furnished to all who ask for them.

Any information that is desired in regard to the meeting and the arrangements may be had by addressing the Secretary, G. S. McLandress, Whiting Building, Albuquerque, New Mexico.

**THE ANNUAL MEETING.**

Will you help to make it a good one?

We have a good program.

We meet in a good place.

Make it a good meeting by helping to secure a good attendance, by being at every session on time, by taking part briefly in discussions, by seeking in every action taken by the Society the highest welfare of the citizens of our Territory, and thereby maintain the honorable record of the New Mexico Medical Society; lastly, but not least important, by bringing the ladies with you.

Acting Governor Jaffa has appointed delegates to the anti-tuberculosis congress which meets at St. Louis on June 4, as follows: Dr. E. Osuna, Dr. G. W. Harrison, of Albuquerque; Dr. W. J. Hammer, Silver City; Dr. J. W. Kinsinger, Roswell; Dr. T. B. Hart, Raton; Dr. F. E. Miera, Santa Fe; Dr. C. C. Gordon, Las Vegas; Dr. F. F. Doepp, Carlsbad; Dr. George C. Bryan, Alamogordo, and Dr. M. G. Padon, White Oaks.

## VAGINAL HYSTERECTOMY.\*

(By Dr. S. D. Swope, Deming, N. M.)

Vaginal hysterectomy is not a new or modern operation. Some time in the fifteenth century a midwife pulling upon the cord, pulled out the uterus, not knowing what else to do, she cut away the mass with a razor.

It is recorded in the works of Para, that upon the Kings day, 1575, the operation was successfully performed the patient dying three months later.

M. Langenbeck and Sauter, intentionally performed the operation in 1822, and they were followed by many French surgeons, nearly all of whose patients died.

Velpau in his surgery of 1835, says, "Removal of the uterus has so long been looked upon as an impossibility, that it has been doubted even in our times, whether it had ever really been done."

Liston's surgery, revised by Samuel D. Gross, and published in 1842, has this to say on the subject: "Some bloodthirsty accoucheurs and operators have attacked the uterus unrelentingly. More than one appears to have been seized with a monomania for cutting out a part, or the whole of the organ. Some forty or fifty women have either their os or their cervix uteri removed. In all of these cases the proceeding was useless, cruel and unnecessary. Such doings are not justifiable and if repeated should be punished by the ex-communication of all professional men of sound sense and principle," and goes on to say that the part may be examined by a hollow tube of tin, polished

inside, gently and cautiously introduced. The os pulled down, diseased portion removed, the sore treated with bland liquids and nitrate of silver to promote healing.

Erichson in 1854 says: "This is a barbarous procedure and one contrary to every principle of good surgery. He suggests paliative local and constitutional treatment.

Storer of Boston successfully removed the uterus and ovaries, reporting the case in the American Journal of Medical Sciences, in 1866, and quotes the discouraging remarks of various British and American surgeons against removing the uterus for any cause.

Hamilton in 1873 mentions the operation and says: "Surgeons have had no better success than that attended by accidental ablation. I cannot therefore consent to place the operation among legitimate surgical expedients, and will not describe any of the methods of procedure."

The operation was really revived in 1876, when antiseptics aseptis and improved technique made it possible and humane.

Cautereau did the operation in 1875. Henning in 1876. Czerny, July 25, 1876. The Cauter-Recamier operation was first done by Czerny, April 12, 1878. Billoth did one operation in 1879. Six in 1880. Schroeder operated five times in 1880, at which time many other German gynecologists began to do the operation.

Tolland, of the University of California, in 1879, says: "When I was in Paris, Lisfranc removed the uterus. The uterus should not be removed unless it has, with a portion of the vagina, protruded externally, when it may be ligated and cut away."

\*Read before the Luna County Medical Society, March 13th, 1908.

Corradi recommended the longitudinal bysection of the uterus when the organ was too large to deliver through the vagina. Isaac Pryor did this operation in 1903 on an unfavorable case with good results.

The average mortality of the operation up to 1885 was 27 per cent. 341 cases having been collected by Post, from Czernys first to the beginning of this year; 123 cases were collected from all sources in 1885, with a mortality of 24 per cent.

As excellent authority as T. Gallard Thomas, in his excellent work on diseases of women of 1880, does not think enough of the utility of the operation to mention it.

Bryant in 1879, says: "This is the greatest operation a surgeon can undertake."

From 1885 to 1890, I have been able to find almost no literature on this subject.

The gynecological and surgical world were apparently resting on their oars and watching the effects of the resurrection of the operation by Bilroth, Czerny and others.

J. T. Binkley of Tacoma, Washington, reports a successful case of vaginal hysterectomy in the Medical News of August, 1890. After one month of careful observation and preparation, the operation was performed in the Fanny Paddok hospital, with the Hunter method. He was assisted by six eminent surgeons and the entire hospital staff. The patient was up and about the room in twenty-one days.

McNutt reported a successful case before the San Francisco Gynecological society, which was published in the Pacific Medical Journal in 1893. This was a cancerous pregnant uterus and he was compelled to bysect the organ before removing it.

George M. Edibohls published a very complete article on the technique of this operation in the American Journal Medical Sciences, January, 1895. His first Vaginal Hysterectomy, was done May 18, 1895.

The International Encyclopedia of Surgery, 1898; mentions the operation but does not give any detailed description of the technique. This valuable work being content with giving some good references and remarking on the increasing popularity and efficiency of the procedure.

Of the crop of surgical publications of 1898, Skene, Wyeth and Howard A. Kelly, legitimize the operation, and recommend it as the elective one in carcinomatous growths of the uterus where the adnexia is not involved.

William R. Pryor, in his Gynecology of 1903, gives a very perfect description of the technique, and devised a set of forceps with movable handles, did away with a great deal of inconvenience of the patient after the operation and were effective. I saw the distinguished gynecologist operate in the Poly clinic, in New York, in the winter of 1903. With his four trained assistants and six trained nurses, he did a beautiful operation. In one of the cases I saw there was secondary hemorrhage from slipping of the forceps. The hemorrhage was controlled and the patient recovered.

Fowler in his Treatise of Surgery, 1906, describes the operation and its technique. In his chapter on treatment of Carcinoma of the uterus, states that early and complete extirpation of the uterus holds out the only hope of cure.

This brings the history of the operation down to the present time. Men like John Deaver, Mayo's Wyeth, Goff and Rodman, surrounded with their able corps of assistants and



trained nurses; with the advantages of modern hospital facilities, no longer hesitate to perform the operation, that the great Erichson in 1854, in the absence of asepsis, designated as "Barberous and contrary to every principle of good surgery." So much for the advance of our beloved science in a period of fifty years.

I wish to report a case of Vaginal Hysterectomy. I think the operation has been done a very few times in New Mexico.

F. R., age 29, single, one miscarriage at three months; a member of the demimonde, consulted me on Jan. 25, 1908, complaining of a constant flow of sero-sanguenous material from her vagina. She had been under treatment for some time, but her physician, an able practitioner, had discovered the character of her ailment, and had given her no encouragement. She is a slender woman, dark hair and eyes, pale and chachetic from loss of blood. She has lost twelve pounds of flesh in the last six months. An examination disclosed a typical cauliflower epitheliomatous growth, completely covering the os uteri and completely obliterating the vaginal portion of the organ. There was a hard area around the outer border of the growth, which suggested to the patient that she was growing a ruffle at that point. The centre was soft and from the whole mass there exuded a sero-sanguinous material.

I advised her that an immediate operation was necessary if she wished to secure any benefit from same; and suggested that when she was under the anesthetic, I could determine whether an amputation of the servix (the operation contemplated) would be of any service. That if I found the disease too far advanced to secure pos-

sible relief I would back out and let her go on her way rejoicing.

On February 5, after carefully preparing the patient in her own home having determined that the functions of all the other organs were normal, Dr. Steed gave the patient chloroform at eleven A. M., and I made a complete examination. I found the uterus rather smaller than normal, fairly movable with some adhesions on the left side from an old cellulitis. The growth extended up to, and in some places including a part of the Utero vaginal fold. The inner os seemed closed tight, but the growth seemed to extend quite to the internal os. After deliberating a few moments I decided that an amputation of the neck and a hollowing out of the diseased tissues surrounding would probably do no good. I laid the matter before Dr. Steed and informed him at the same time that the case was a favorable one for vaginal hysterectomy, and asked his advice as to proceeding with the operation. In consideration of the fact that a lingering, painful death was inevitable if nothing was done; the poverty of the patient and the small reason for attempting to prolong her life in the present condition, the doctor agreed that if I thought I could do the work without assistance I had better run the risk.

I then opened the posterior culdesac and determined that the uterus was apparently normal above the internal os. That there were no adhesions except on the left side and they not very extensive. I could not amputate and close the os, as the diseased area was too extensive for that premonitory procedure. I then enlarged my dissection, retroverted the fundus and proceeded to clamp off and ligate the blood supply, after the suggestions of Pryor, Wyeth and Bryant. I had

quite a little trouble in separating the adhesions about the rectum. The ligature slipped from the left uterine artery. As my patient was getting pretty weak, I clamp an artery forcep on the bleeding vessel, finished the operation by closing the vaginal vault with one stitch, packed with iodoform gauze and put my patient to bed, with feeble respiration and a pulse of 130. It required in all 45 minutes to complete the operation after the anaesthesia was complete. The patient had a hypodermic of strychnia, and a normal salt enema. She reacted promptly, and was able to make her wants known in two hours. It was then I discovered that my patient was addicted to the use of morphine, she having denied this to me previously. She took enormous quantities of the drug, about six grains every four hours, which we were compelled to continue during her convalescence. We had a small vagino-rectal fistula after removing the first packing, which closed in four or five days, was probably due to the breaking up of the intimate adhesions in that quarter. There was quite a little irritation of the bladder, which gradually disappeared, otherwise my patient made an uneventful recovery, was up on the nineteenth day and about the house from that time on. I have the pleasure of presenting her this evening to the society, on the thirty-seventh day after her operation, apparently cured. She has gained ten pounds, is eating and sleeping well, understands what she has been through and is glad she is living. You will see that the wound has completely closed, only a small red line marking the former site of the os.

There have been many successful vaginal hysterectomies performed. There have been very few performed under such difficulties as I had to en-

counter in this case. With absolutely no assistance save the valuable help of my colleague Dr. Steed in giving the chloroform; performed without an operating room, and cared for by a woman, who, though willing and attentive, had had no experience as a nurse. I would feel prouder of the success of this case, were it not that I sometimes remember "That fools rush in where wise men fear to tread."

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Next Annual Meeting, Albuquerque. September 2nd and 3rd. Don't fail to attend.

### OPHTHALMIA NEONATORUM.

(By W. G. Shadrach, M. D., Albuquerque, New Mexico.)

I select this subject not that I have anything new to present, but on account of its being more interesting and important to the general practitioner of medicine from its prophylactic standpoint than anything I can think of in so short a time, having been asked to prepare a paper for the next issue of our Journal which goes to press in a few days.

Gonorrhoeal Ophthalmia, so called in the adult, Ophthalmia Neonatorum (new born) so called when in the eyes of an infant, is one and the same trouble, with a common cause, the *Gonococcus* of Neiser. While the cause is identical, quite different results are obtained under the same proper treatment; so much so, that you can as a rule promise good results in an infant when seen early, but in an adult you never know what the results will be. I know of one case which was well and properly treated, within the confines of this city, but the patient lost her vision entirely, the loss of sight being due to ulcerative corneal destruction, there not being enough clear corneal tissue left for a satisfactory iridectomy.

Gentlemen of the medical profession: if you stop and think a moment of the number of blind children filling our public and private institutions, of the cost of maintaining such, of the sources of infection, of the wonderful beneficial results that prophylactic treatment has given, you will readily realize how responsible your positions are in carrying out Credes method of treatment, and seeing that midwives do their duty in this regard.

I am glad to note that New York, Pennsylvania, Ohio, Virginia, and many other states have enacted laws

making it a misdemeanor subject to fine or imprisonment or both, for any individual, not a physician doing obstetrical work, who fail to report a case of sore eyes in the new born to proper health authorities.

In conclusion I will detail both the prophylactic and treatment of a developed attack:

*Prophylactic Treatment.* As soon as the head is born the lids are gently and carefully cleaned with a warm saturated solution of boric acid, and 2 gtts. of a 2 per cent solution of Nitrate of Silver, instilled into the conjunctival sac, followed by cold compresses as soon as the child is born, which aids in preventing the silver reaction we occasionally get. If the mother is known to have gonorrhoea it is hardly necessary to add that the child should be isolated; this treatment is known as the method of Crede.

*Treatment of Developed Attack.* If the eyes are seen while the cornea is still clear, prognosis is good, and the case usually brought to a successful termination. First, foremost and always, ice cold applications for **at least** half the time, applied to the eyes by means of pieces of gauze (plain) kept on a block of ice close to the bedside; this is used while the inflammatory action is "going up," but as soon as the active trouble comes to what seems to be a standstill, decline, or the cornea becomes hazy, cold is contraindicated. If you consider the nature of the corneal tissue and its base of nutritious supply the reason for this substitution is readily understood.

Removal of discharge as often as you can see any is absolutely necessary, and remove it gently without touching the corneal epithelium which may be readily broken leaving a source of infection, producing an



ulcer, a thing we wish studiously to avoid.

Solution of Sulphate of Atropia (4 gr. to Aqua I ounce) one drop every 4-6 hours, and oftener, is indicated unless the pupil is very large. You want to relax accommodation and keep it so, consequently use the solution of atropia in sufficient quantity to accomplish the desired result.

Contraindications for Atropia. Ulcer near the sclero corneal margin that is liable to perforate; in such a case, Eserine is to be used to pull the iris to the center of the cornea thus preventing prolapse.

Warm saturated Boric flushing is a valuable adjuvant; be careful to direct the force of the stream in upper and lower cul-de-sacs and not on the cornea.

Instillations of the following drugs are good; I mention them in the order of their value according to my experience in their use; every druggist in this city knows my preference for Argyrol solutions in the treatment of eye inflammations, and I find a 5 per cent solution will do the same good work that a 25 per cent solution will do, not an unimportant point when you consider the cost, for Argyrol is expensive. Protargol is good, but more irritating, hence not to be trusted to a patient with the same feeling of safety as Argyrol Argentamin and Largin are highly lauded by some though I have had no experience with them. When I find a drug that I know is good I am slow to give it up, or even to try another in its stead.

When the discharge is profuse a solution of Nitrate of Silver gently, but thoroughly applied to the everted lids, after cleansing with boric flush, is a valuable help; this is often interfered with by hard, thick swollen lids when a canthotomy is indicated, which

not only aids you in applying this remedy, but it also takes the pressure from the cornea and enables it to get its nutrition more readily; it also depletes the surrounding tissues somewhat.

We should have in mind always "protect the cornea" and every means to that end should be carried out, the least disturbance to epithelium of the cornea often being the starting point to complete destruction of the eye.

At some future time I hope to write a paper on this subject that will be worth the while; for the present I am simply writing at random, consulting magazines, textbooks, etc. For my part a paper without something new, original and out of the routine work, has no place in a medical journal. We should have an aim to making a paper interesting and instructive with something out of the general order.

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#### REPORT OF SPECIAL HEALTH OFFICER.

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(By B. Ruppe, Special Health Officer of New Mexico.)

Tucumcari, N. M.,

May 26th, 1908.

Honorable Board of Health,  
Santa Fe, N. M.

Gentlemen:—

I have just arrived at Tucumcari, after a strenuous seven-day overland trip from Texico to this place and respectfully report that at Hollene, thirty-three miles north of Texico, I found Dr. D. C. Stahlman practicing without being registered and at Grady, I found Dr. J. L. Brown practicing without being registered. I had to travel thirty-three miles to get a Justice of the Peace, who fined them each \$50.00 and costs.

Yesterday, Sunday, Dr. Russell of Tucumcari was kind enough to go with me and I procured an automobile and checked up the Towns of Roose-

velt, House, McIlister, Dodson, Quay and Ard, which are all new towns in this county, and this morning before Squire Saxon, I swore out seven complaints. I will have to stay here until these cases are tried, as some of the defendants live fifty miles from Tucumcari. We left at 7 o'clock in the morning and returned at 9:30 in the evening, covering one hundred and fifty miles.

On our return trip last night, I was entertained at a banquet given by the Medical Society of Quay County, which was presided over by the veteran practitioner of medicine, Dr. Pring, while Dr. Thompson acted as Secretary. The following prominent physicians were present: Dr. Crume, Dr. Colson, Dr. Manney, Dr. Russell. Dr. Parvis of Boston, Mass., was one of the invited guests.

Your representative appreciates this honor above all others as it shows what organization will do. When I reported to you last, the result of my February trip. I recommended the forming of county organizations for the purpose of checking illegal practice of medicine, making it the duty of the Secretary of the County Association to report all violations of the law to the board of health directly. All of the above mentioned physicians have done everything in their power to make my stay as pleasant and agreeable as possible. They have rendered me every assistance and have shown a disposition to assist me in fulfilling my duties. Under such conditions, it is easy for any health officer to get over the ground quickly, as it gives him a cue to start from and assists him in procuring the necessary witnesses. I find this is absolutely necessary in all prosecutions as the Justices of the Peace, Grand Juries and Petit Juries do not consider the illegal prac-

ticing as a crime and only with a preponderance of evidence can a conviction be had.

It is an easy matter after the County has been duly organized that the Board of Health can keep in touch with them and successfully cope with illegal practice. Consequently, every effort should be made to have an organization in every County, so that each legitimate practitioner can be in touch with what concerns not alone the profession, but the health of the community at large.

The trial of the cases I filed yesterday will be held this afternoon at 3 o'clock and the result thereof, I will make in my next report.

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#### VAGINAL HYSTERECTOMY IN A PREGNANT WOMAN—RECOVERY.

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(By Howard Crutcher, M. D., Roswell, New Mexico; formerly Surgeon to the Chicago Baptist Hospital; formerly Instructor of Surgery in the University of Illinois.)

The conditions requiring the performance of vaginal hysterectomy in a pregnant woman are necessarily of extreme rarity. The present case, occurring in the practice of Dr. Galloway and myself, seems to me to be worthy of record.

A married white woman, age 31, with pulmonary tuberculosis, mother of two children, one of whom died in infancy of tuberculosis, became pregnant for the third time, and was almost immediately afflicted with pernicious vomiting. No remedy seemed to benefit this condition in the slightest. In the meantime, the pulmonary tuberculosis blazed into renewed activity, and showed symptoms of running a rapidly fatal course.

After careful reflection, we decided to terminate the pregnancy and made repeated efforts to do this by dilating and packing the uterus. This organ

was so badly displaced that the cervix pointed almost towards the umbilicus. The muscular tone of the uterus seemed to be almost entirely lost.

The condition of the patient became so critical that at the end of the tenth week we decided upon a vaginal hysterectomy. The operation was performed on April 12th. There is nothing about the operation that is worthy of special comment, except that clamps were used, and allowed to remain for 48 hours, and that the entire operative work occupied only eleven minutes. The patient did not lose more than a teaspoonful of blood. She made a rapid and apparently complete recovery. The vomiting subsided at once and the tubercular process in the lungs has again become quiet.

I am aware that the clamp operation is looked upon with extreme disfavor by many eminent surgeons, yet it has distinct advantages in its favor. The operation may be done with clamps far more rapidly than it can be done by the use of ligatures, and comparatively few men, in my judgment, are properly qualified to perform a hysterectomy with ligatures. My belief is that the clamp will retain its position as an invaluable aid in selected cases of hysterectomy, although the ligature has, and will continue to have, a majority of advocates.

#### THE MEDICAL ERA'S GASTRO-INTESTINAL EDITIONS.

The Medical Era, St. Louis, Mo., will issue its annual series of gastro-intestinal editions during July and August. In these two issues will be published between 40 and 50 original papers of the largest practical worth, covering every phase of disease of the gastro-intestinal canal. Sample copies will be supplied readers of this journal.

#### SLEEPLESSNESS.

(By Dr. John W. Colbert, Surgeon to Santa Fe Coast Lines, Albuquerque, N. M.)

Sleep as defined by Dana is a condition in which consciousness is normally lost and in which the whole body, but particularly the brain, enjoys functional rest, while constructive and nutritive activity goes on. Sir James Sawyer describes it as an appetite; that is, a craving produced by the recurring wants and necessities of bodily or organic life. But little, or nothing, is known of the exact molecular alterations in the brain that constitute sleep. There are many theories, but until the action of the living cell can be studied all theories must be regarded as only speculative. The older investigators tried to localize the cause in the thyroid or the arachnoid plexus. Somner believed it to be the result of reduced oxygen in the brain. Other investigators have regarded sleep as an auto-intoxication, brought about by the circulation of waste products in the blood. Still others believe in the existence of a sleep center. The theory which seems to have the greatest number of supporters at the present time is that fatigue of the vasomotor center produces arterial dilation with a resulting anaemia of the brain. It is true that during sleep there is more or less pronounced cerebral anaemia, but is this phenomenon a cause or an effect? It is an established law that the cessation of functional activity is followed by a lessening in the amount of blood in the part. It would seem, according to this, that the sleep, or cessation of functional activity is the cause of the anemia, and not the anemia the cause of the sleep. At present it seems best to consider it a function of the cortical brain cells when exhausted to pass into a condition of inactivity, during which their



power of further effort is recuperated. We must bear in mind that the cortex of the brain is an exceedingly complex structure. Seven or eight cortical layers have been described, each differing materially from the others, and very little or nothing is known of the function belonging to each layer of cells. Since nothing definite is known regarding the causation of sleep, it is quite evident that its disorders must be studied from a purely clinical, and hence somewhat empirical point of view.

Sleeplessness, or insomnia, is a condition frequently met with in medical practice. It is a very important disorder, and if understood and properly managed there is no disease more amenable to treatment. It not only produces great suffering, but in itself may lead to severe mental disease, and therefore, its consideration is of vast importance. In itself, sleeplessness is not a disease—but is a symptom of some functional or organic disorder. Sleep will be prevented if the brain cells instead of entering upon a natural period of repose continue in their unusual activity. The causes of a continuation of this activity are numerous, and for consideration, sleeplessness may be classified according to cause as follows:

I. *Sleeplessness of Psychic Origin.*—Grief, mental anxiety, worry, pain, intense study, neurasthenia, melancholia, etc. This form includes hereditary and habit insomnia. The inability to sleep is not dependent upon any discoverable underlying disease or morbid condition, and is frequently present in persons whose general health is in other respects good. The nervous temperament is a predisposing cause in most of these cases, and the sleeplessness is perhaps due largely to vasomotor paresis of the intracranial

blood vessels as a result of exhaustion probably induced by unnatural excitation of the cerebral cells.

II. *Sleeplessness of Toxic Origin.*—Alcoholism, gout, Bright's disease, gastric and intestinal disorders, coffee, tea, drug habits, etc. In these cases the sleeplessness is most likely due to some noxious agents that produces cerebral hypermia.

III. *Sleeplessness of Senile Origin.*—Due essentially to cardio-vascular influence, as for instance, degeneration of the small cerebral vessels. This condition results in permanent dilatation of the vessels.

The most frequent causes of sleeplessness are to be found in the nervous system. It is usually one of the most troublesome symptoms in neurasthenia. It is marked in melancholia; a common symptom in the various forms of insanity, especially in mania and paresis, when it is accompanied by intense restlessness. In the neurasthenic subject there is much mental activity and the patient does not sleep because he is continually thinking over the affairs of the day. The insomnia is usually in the form of irregular and unrefreshing sleep accompanied by dreams. In the melancholia patient the sleep is broken and generally disturbed by dreams, or the patient wakes at three or four in the morning and is unable to get to sleep again because of the disturbed thoughts which come to his mind, and in some of these cases sleep is absent altogether for long periods.

*Symptoms.*—Some patients readily fall asleep, but soon awake and remain awake the rest of the night, or simply secure fitful periods of sleep. Others roll and tumble for hours before getting to sleep, but when once asleep do not usually awake until morning. Still others report that they sleep in frag-

ments only—broken sleep—and in the morning are not properly rested. In most cases of insomnia, especially those of psychic origin, the patient gets more sleep than he believes, and with some it is impossible to convince them that they slept at all. Much loss of sleep produces impairment of nutrition, brain exhaustion, weakened muscular force, and sometimes mental symptoms. The appetite is often impaired or digestion is diminished. The eyes generally lose their clearness and appear dull. Complete insomnia rarely occurs, and when it does, death takes place in ten or twelve days.

*Treatment.*—Sleeplessness must be attacked at its cause, when possible to ascertain the primary cause, and must only be treated symptomatically when repeated examinations fail to give results. All hereditary, digestive and reflex causes should be systematically investigated, and it is often advisable to examine the thoracic and abdominal as well as the sexual organs. Very frequently it becomes necessary to make a radical break in the patients' habits before any improvement can be secured. The measures that should be employed to produce sleep are too long to set forth here in full, and only the most important can be mentioned.

Of first importance is a strict observance of the hygiene of sleep. This means getting the body into such a state, and to place it under such conditions and circumstances that sleep is a natural and inevitable result. The sleeping apartment should be well ventilated and comfortable. The patient should exercise great regularity in everything, and the mind should be kept from exciting occupation, especially toward evening. Educate the patient into a way of life in which he does not carry his worries to bed.

Physical therapy should next be

brought into play. By this I mean the use of the warm bath or douches, electricity, and massage. The effects of a hot bath taken quietly at bed time is well known. A glass of hot milk, or hot lemonade, or hot water acts beneficially in decongesting the head, and with the hot bath encourages the dilatation of the cutaneous vessels and establishes the circulatory conditions found in natural sleep.

The careful use of massage gives very gratifying results in many cases. It increases the nutrition of the tissues, stimulates metabolism and draws the blood to the surface of the body, thus tending to relieve visceral and especially cerebral congestion.

Electricity is undoubtedly of value in predisposing to sleep. Electricity and massage may be employed in conjunction. Of the currents, both the galvanic and faradic may be used.

In many cases of sleeplessness the administration of quieting, calming and sleep-producing drugs is indispensable. I believe that there exists too much prejudice, both on the part of the profession and the laity, against the production of sleep by such measures. The physician often hesitates in using hypnotics and the sleeplessness continues unchecked until very grave symptoms arise. The sleeplessness may be due simply to some overstrain of the brain centres and a few doses of medicine may set it aright. Many times it happens that a week's good sleep will allay the excitement and irritability and disperse the threatened mischief. The administration of hypnotics should, however, be done with a definite purpose.

Chloral is the surest of all hypnotics and most satisfactory in its effects. The dangers from its use, I believe, have been overestimated, consequently an inferior drug has often been given

in its stead, and frequently to the detriment of the patient. With no drug is the sleep produced so natural, so lasting, or so refreshing as that produced by chloral. In rare instances, probably in cases of anaemia with want of tone of the vessels, it may produce headache and depression. It weakens the heart's action, dilates the peripheral vessels, lowers arterial tension, reduces the body-temperature and produces anemia of the brain—in fact, it brings about all the known phenomena of natural sleep. Its symptomatic effect becomes operative in from ten to thirty minutes after its administration, and usually lasts about seven hours, and the patient generally awakes refreshed. In my own experience I have many times given large doses—30 to 40 grains—and sometimes to patients with weak hearts, and so far without a bad result. It is extensively used in our insane asylums and sanitariums—yet the average general practitioner is afraid of it. Potter says, "Several hundred grains have been taken at a time in more than one instance without fatal results."

Sulfonal and Trional are perhaps used more often than any of the hypnotics. Both produce hypnotic effect by direct action on the brain cells. Trional is of advantage over Sulfonal because it can be administered for a prolonged length of time and does not produce the circulatory, digestive and renal disturbances sometimes caused by the use of Sulfonal. The two drugs are often given in combination with very good results.

In full medicinal doses the bromides diminish the reflexes and allay excitability, and are thus conducive to sleep. They are of advantage where mild and continuous action is desired, and should be given during the day—preferably at noon, 6:30 P. M., and bedtime.

Hyoscine hydrobromate acts upon the spinal and cerebral cortex, and is to be used in the insomnia of the insanities in which great motor excitement is present. A hypodermic of hyoscine hydrobromate (1/100 gr.) and morphine sulphate 1/8 or 1/4 gr.) will quiet the worst cases of mania almost as soon as it is administered.

Opium is especially indicated in the insomnia accompanied by pain, and sometimes in the insomnia of the insanities. Instead of producing the conditions of normal sleep it simply causes unconsciousness by intoxication which may or may not be followed by sleep. An occasional dose is practically harmless, but continued use cannot but be harmful.

Paraldehyd, amyl-hydrate, somnal and many other preparations have been recommended for insomnia, but I have had no personal experience with them and will not consider them here.

In conclusion, I wish to emphasize the following points regarding treatment:

1. In the treatment of sleeplessness the great principle of therapeutics—the removal of the cause—should ever be kept in mind.

2. The simpler methods should be tried before medicinal treatment is resorted to.

3. That drug should be used which will show its systemic effect when the sleeplessness is due. For instance, in cases experiencing difficulty in getting to sleep, chloral may be given thirty minutes before retiring; cases awakening at one or two may be given sulfonal or trional at bedtime, etc.

4. Do not abuse hypnotics—but do not permit foolish prejudice to keep you from their use when the simpler methods fail.



**SURGERY OF THE GALL BLADDER.\***

(By Dr. D. H. Carns.)

In presenting this paper on a subject upon which have been written volumes by the ablest Surgeons of the World, the Author has been prevented by limited time from fully and comprehensively covering it, and will merely confine himself to the observations and results obtained by different operators, pointing out the newer ideas and methods, and if he succeeds in placing before you anything useful, or new, he will feel well repaid for his efforts.

To consider all the affections of the Bile tract from a Medical and Surgical aspect would require a volume.

We will content ourselves by considering the Surgical phase only. The work of Riedel and Kehr in Germany, Moynihan and Robson in England, and Mayo, Richardson, Deaver and Murphy in America, has of late years placed the surgery of the Bile passages, especially Cholelithiasis, upon a permanent basis.

The operative work has elucidated obscure points relative to cause, pathology and diagnosis, assisted by the brilliant researches and careful post-mortem work.

As in appendicitis, so in gall bladder work, it remained for the surgeon to show how different is the process in life, from the end result as shown post-mortem.

There is no doubt that cholelithiasis, cholecystitis and all their results, near and remote, should be really classed as consequences of infection.

The infection may not always be demonstrable in its results, and causative factor not always to be found when the damage has been done, yet the inflammatory factor is the important one in all save malignant disease of the bile tract.

While there is still some differences of opinion concerning the exact forma-

tion of gall stones, all authorities seem agreed that they are generally caused by bacteria.

The effects of stasis of bile, peculiar chemical composition of bile, and the condition of the gall bladder musoca are not so well understood.

Under the old classification of causes were given:—Predisposition in persons of a bilious temperament, those of a catarrhal tendency in other mucous membranes, extension of inflammation from the duodenum and stomach, exposure to cold and dampness, checking of perspiration, errors of diet, acrid substances, certain drugs, inhaling noxious gases, obstructive cardiac disease, impeded pulmonary circulation from lung disease, tumors of abdominal cavity, enlarged glands, malaria, syphilis (second stage), gout, phosphorous and lead poisoning, cholera, typhus, typhoid, pyemia, septiciemia, and other fevers, presence of parasites, starvation, and occupations exposing patients to great extremes of temperatures.

While this classification is held by many, even now, the consensus of opinion points more forcibly to bacterial infection as the prime factor. The bacteria considered as the principal causes are:—*B. colli communis*, streptococi and staphylococi and the *B. typhosus*. Futerer states that organisms injected into the circulation appear after a few moments in the bile. Flexner and Chiari have shown the constant presence of *B. typhosus* in the bile of patients dying of typhoid, and Carnac records a case of acute cholecystitis in the first few days of an attack of enteric fever, with operation and isolation of the *B. typhosus*. Deaver reports a case wherein the bacillus was located and isolated 41 years after an attack of typhoid.

\*Read before the Bernalillo County Medical Society, April 1st, 1908.

It can be safely assumed that bacterial infection exists in all cases. Concerning the mode of infection there is much doubt, yet in most cases it is apparently by means of the portal circulation. The character of the infection varies.

Much stress has been laid upon enteric fever as a causative factor of cholelithiasis. Deaver, in a series of 182 cases of calculous cholecystitis, found that 28 per cent, at some time or other, had typhoid. The interval between the occurrence of typhoid and the symptoms of cholelithiasis vary from a few weeks to many years. In several cases he was able to recover the bacillus from the gall bladder at the time of operation, in one case as long as 41 years after the occurrence of the acute infection.

In his bacteriological investigation of 182 cases, 46 cultures were sterile, 25 contained the *B. communis*, 13 with *B. typhosus*, 5 with staphylococci, 3 unidentified, 2 with a *B. communis* and staphylococci and one with a *B. subtilis* and calculi. In practically one-half of these, the cultures were sterile, this is not so remarkable since the fact that the most favorable cause for formation of gall stones is mild infection by an attenuated culture of an organism whose virulence has been decreased to a minimum.

Thus it is easy for stones to form and the bacteria to die gradually, and be absent at the time of the operation.

The various bacteria have been found to give rise to practically the same processes clinically and pathologically, and each or any one of these mentioned may be the causative agent in any form of infection.

Besides infection as a causative factor producing gall stones, we have been able to confirm statistics of sex and age, thus 139 out of 182 cases were females.

Deaver and others deny the association of family history, of gastric or biliary cirrhosis, or any sign of such a thing as "cholelithic diathesis." Thus, the ablest surgeons, to a great extent, demolish the old classification of causes, and insist that the prime cause is bacterial invasion and infection, thus separating us from our time honored causes—"Heredity, errors of diet, faculty metabolism, or digestive disorders,"—and in their place install bacteria as the cause. The pathological processes associated with gall stones may be classed as follows:

1st. Those concerning the stones themselves and their mechanical action; 2nd, those concerning the biliary passages and liver; 3rd, those entirely beyond the biliary tract.

They vary in size from fine sand to a hen's egg. They may be present as one or hundreds. Murphy of Chicago removed 228 from one gall bladder. Out of 182 cases of Deaver's, the following table records the location of the stones in this series:

Gall bladder .....	107
Gall bladder and choledochus.....	24
Gall bladder and cysticus.....	26
Gall bladder and choledochus cysticus..	2
Gall bladder choledochus, hepaticus...	2
Choledochus only .....	12
Cysticus only .....	6
Gall bladder, cysticus, choledochus and hepaticus .....	1
Choledochus and hepaticus.....	2
Total .....	182

The most important deductions from this table are: 1st, in case of hydrops, there was either a stone in the gall bladder only, or in the cystic duct, at times with associated stones in gall bladder and choledochus. 2nd. In the majority of cases the calculi, even when causing symptoms, are found in the gall bladder alone. 3rd. The rarity of finding stones in the hepatic duct, which, with other facts, shows that, while calculi may be found within the hepatic duct, their point of origin undoubtedly is in the gall bladder in most cases.

Among the pathological processes found in the gall bladder and biliary passages, the most important are:

1st—Cholecystitis, subdivided into—

A—Acute,  
Catarrhal,  
Purulent-empyema,  
Hemorrhagic,  
Ulcerative,  
Gangrenous,  
Phlegmonous.

B—Chronic,  
Catarrhal,  
Hydrops,  
Obliterative.

2nd—Cholangitis.  
Acute catarrhal,  
Acute purulent,  
Chronic catarrhal.

3rd—Hepatitis—  
Acute or purulent  
Chronic or cirrhotic.

4th—Peri cholecystitis.

5th—Localized peritonitis with abscess.

6th—Perforation of gall bladder.

7th—General peritonitis.

8th—Biliary fistula.

9th—Carcinoma.

10th—Pancreatitis.

We may well pass over a detailed description of these owing to time, and refer you to the text-books for a detailed description, and next touch upon the symptomatology of gall stones:— These give a variety of symptoms of endless combinations. It has been stated that they do not in most cases cause symptoms. This is erroneous. More properly, the facts are that they usually do not cause the symptoms commonly recognized as classical ones in this condition, but by ones, which, until recently, have been misunderstood as to their diagnostic significance and minimized as to their importance.

The symptoms are pain, jaundice, fever, tumor, nausea, vomiting, and last, but not least, that group occurring in cholelithiasis often long before the recognized signs, and vaguely classified as stomach and liver troubles, billiousness, and indigestion.

Sharp pain in the epigastrium, or gall bladder, referred in many cases to the shoulder, chest or back, is the one cardinal symptom of the disease in the chronic form. Jaundice as a symptom has of late been discredited by many.

Murphy states that he found it in but 10 per cent of his cases, but many authorities state that this absence is due to imperfect or faulty histories, and that at some time or another jaundice existed in at least 75 per cent of the cases, at times it is true, being but slight and confined to the sclera, but it was, nevertheless, a true icterus.

Jaundice usually follows the colic or pain, in rare instances it is the first symptom. Accompanying jaundice are the three clinical manifestations, biliruria, absence of bile in the stools, and itching of the skin. The nausea and vomiting, the tumor in the region of the gall bladder and the indigestion need but passing mention here.

Touching upon diagnosis and laboratory methods, we have three: 1st, the leukocyte or differential count; 2nd, the X-ray; and, third, examination of the feces. The latter two do not give the results warranted, but the first, the leukocyte or differential count is certainly of value, especially in the purulent condition of the biliary passages. Oft-times supposed stones are found in the feces, which are nothing more than globules of olive oil turned into soap in the passage along the bowels.

The diagnosis of gall stones is easy or difficult, depending upon whether the pathology and symptomatology of the original disease is masked by the existence of adhesions of the upper abdomen, then the distinction between gall stones and chronic gastric ulcer, or stone and non-calculous cholecystitis, often becomes a very fine one.

The diseases more likely to cause difficulty of diagnosis of gall bladder disease are appendicitis, renal calculus, gastric crises in certain nervous affections, and many others.

In all of these a careful study will generally clear the diagnosis without much difficulty.

Treatment of cholecystitis and cho'le-



lithiasis from a therapeutic standpoint must of necessity be palliative, indirect, long continued, and uncertain; permanent relief to the patient can only come by surgical intervention.

The medical relief is limited to relief of pain in acute attacks, and efforts to keep the stones quiescent in the intervals. There is no remedial agent known for the solution or removal of biliary calculi. Surgery of the biliary passage is now firmly established. For a reason for its existence we have only to look at the long list of complications of gall stones in neglected cases.

Its consideration may be divided into three parts: 1st, the indications for surgical intervention; 2nd, the results of surgical intervention; and, 3rd, the contra-indications for surgical intervention. The indications are, first, repeated attacks of biliary colic; 2nd, hydrops of the gall bladder; 3rd, stone in the common duct; and, 4th, the existence of any of the complications, especially of the acute infections.

The first three do not always demand immediate operation, the last one nearly always does:

The results:—Mayo, in 1,500 cases, gives a mortality table of 66 cases (4.4-10 per cent) this includes acute perforations with septic peritonitis and malignant disease.

In a later list he gives the following:—Adhesions of gall bladder, three cases and three recoveries; carcinoma of gall bladder and ducts, eight cases; six recoveries. Cholecystectomy, 100 cases; 98 recoveries. Cholecystenterostomy, four cases; three recoveries. Cholecystostomy, four cases; three recoveries. Cholecystitis, with or without stones, 108 cases; 107 recoveries. Cholecystostomy, for stones in gall bladder or cystic duct, 153 cases; 152 recoveries. Choledochotomy, stones in common duct, 52 cases; 51 recoveries, with 16 other operations, including five cases of

malignant disease of the pancreas with 12 recoveries.

The contra indications for operation may be summarized as follows:—Organic disease of the heart, lungs and kidneys, extreme age, anemia, or slow coagulability of the blood, and cholemia. The main features to be borne in mind in surgical treatment are these:—that it is absolutely necessary to a cure in most cases of chronic biliary infection, whether calculous, or non-calculous, and that when undertaken early the risks are infinitesimal, compared with those encountered when complications have set in. A knowledge of the contra indications and failures should not deter us from operation, but lead us to operate earlier and often on suitable cases. The permanent cures will be larger and the mortality correspondingly lower.

#### Operative Treatment

There are two methods of operation, the immediate or single-step, and the mediate or operation of two sittings, the former method is employed by those very dextrous operators who are constantly engaged in this work, and feel sure of their ground, the latter is more applicable to surgeons who do occasional surgery, as it lessens the liability to infection. Immediate: make a vertical incision three inches long from the tip of the tenth rib downward, extending it if necessary. The gall bladder will be found presenting when the cavity is opened. The bladder must be first aspirated of its contents. Protecting gauze is inserted around it to avoid soiling and infection, and an incision large enough to admit the finger, is made in the bladder in the direction of its axis and near its fundus. The finger is then introduced and detects the stone as nothing else will. Then a pair of large-jawed dressing forceps, with spoon-shaped blades, is introduced

and used in extracting the stone. Search should always be made along the common duct to detect hardness of another lower calculus. The opening of the bladder must be brought to the peritoneum by sutures and a drainage tube put into it and secured by a safety pin. The lower part of the wound should be closed up to the open gall-bladder and provision made for the discharge of the bile, this is best done by inserting a glass tube into the rubber drainage tube and attaching a longer rubber tube to the glass and running it into a flat flask which is encased in the dressings. After about ten days the tube may be removed, as the bile will then flow spontaneously. In about two weeks a pad may be placed over the sinus to partly dam back the bile, and when bile appears in stools a firm pad and strapping will close it about the end of three weeks. The Mayo operation, in brief, consists of an incision from the junction of the bony and cartilaginous portion of ninth rib vertically downward for about three inches. The ordinary method of opening the abdomen and packing around with gauze is used, or a rubber dam such as dentists have is used.

If the gall-bladder is enlarged, puncture and aspirate, incise gall-bladder and remove stones, etc., using scoop and strips of gauze. Place rubber drain in gall-bladder. Purse string suture of cat-gut placed about incision in gall-bladder, one stitch through tube. Edges of incision in gall-bladder inverted and purse-string tightened and tied, but not cut. Then suture peritoneum and muscles with cat-gut. Tension sutures of silk-worm gut through skin to include deep fascia. The long sutures of the purse-string in the gall-bladder are now tied to one of the silk-worm gut sutures outside of the abdomen so as to suspend the gall-bladder and keep tube in position. Thus the gall-bladder is not,

as is frequently done, drawn outward to the parietal peritoneum, and hence has the same natural relations with the liver that it has normally.

Ideal cholecystotomy is applied to that operation in which immediate suturing of the bladder incision by a double row of Lembert sutures and returning it to the abdominal cavity.

This is not generally recommended except in simple cases where it is absolutely certain that the bile channels are freely opened.

#### **Cholecystectomy.**

It is quit easy to separate the gall bladder from the liver by blunt dissection, from which there is no severe hemorrhage. Placing a ligature around the cystic duct easily allows its removal. The utility of this operation is questioned, as there is absolute destruction to the channel by which the bile reaches the surface. It is more to be advocated in cases of malignancy or when chronic atrophy has left distorted or sacculated bladder.

#### **Choledeochotomy.**

Or incision into the common duct is an important and interesting proceeding. In doing this operation it is better to raise the shoulder and lower the hips of the patient so as to cause the colon and small intestines to fall away from the site of operation. The liver is held up by an assistant and the colon drawn toward the middle line and downward, a large sponge being placed on the median side and one in the kidney pouch, an incision of the peritoneum of the posterior wall is made from the cystic duct downward on the outward side of the duodenum toward the kidney.

Through the incision it is possible to lift up with the finger the first and second part of the duodenum and to explore and to examine the under side of the head of the pancreas and the common duct at its lower part.

The duct lies upon the portal vein, and the cystic artery lies alongside of it. The distention of the duct by a stone, however, gives little risk of cutting back of it.

An incision the full length of the duct will allow the stone to be easily removed. The duct may be closed with a continuous suture. A second layer of sutures may be taken, but this is unnecessary.

#### **Cholecystenterostomy.**

For years the great hope of the surgeons was some safe method of uniting the intestines to the gall bladder.

The reason for this was to return the bile to the bowel and it was the problem with which Von Winewarter occupied himself and he was the first one who attempted to solve this problem. His method was to stitch the gall-bladder to the colon and to suture both to the abdominal wound. Then, waiting until adhesions had formed, he incised the adjacent part of each and sutured the opposite sides of the cut together, thus attempting to compel the bile flow to enter the bowel.

In 1889 Terrier made a successful operation along these lines and during this time many other operators had attempted this same process in different countries with varying results. The use of Senn's boneplates came into vogue at a later date, but it remained for Murphy of Chicago to devise a mechanical device which has not only made it popular but has made it ideally successful. This was in 1892.

The device which Dr. Murphy uses is the Murphy button, which, up to the present time, stands without a peer.

From 1892 to 1895 the list, as given by Murphy, recorded 38 cases of cholecystenterostomy, with but one death. These were not his own cases alone, but had been operated on by 20 or more

different surgeons, so that the device can be said to be universally available.

The gall-bladder and intestines having been liberated so as to be approximated easily, the bladder is emptied by aspiration and a stout silk suture applied to act as a purse-string around an incision one inch, through which to remove the stone and introduce the button. The string is then drawn tight around the stem of the half-button, which is held in place by forceps. The same steps are taken in the side of the deudoneum. The fingers of each hand grasp the half-button, and when the clamp is taken off, the two stems are telescoped until the rim tightly fix the intestines and bladder together.

As I said before, in speaking of gall-bladder operations for removal of stones, there are two operations—mediate and intermediate.

The Immediate operation is the one in which the gall bladder is opened and stitched to the side of the abdominal wound and the stone removed at one sitting, or after removal of the stone stitch the gall bladder and drop it back into the abdomen.

The mediate operation, the one as used by Murphy, consists in exposing the gall bladder, packing around it with gauze to ward off the peritoneal cavity and inserting sutures from the abdominal wall into the outer coats of the gall bladder. He then inserts a purse-string suture for about two inches along the gall bladder in the direction of its long axis. These stitches go through all the coats except the mucosa.

The dressings are applied and the patient is removed to await the formation of adhesions and after a lapse of two days the gall bladder is incised inside the purse string sutures, the contents evacuated and the stones removed.



The reason for the purse string sutures is simply a line of identification so that in making the incision on the second day, he is sure that he is cutting into the gall bladder and not opening into the peritoneal cavity. The sutures simply act as a landmark, otherwise this operation is the same as the immediate operation. By walling off the gall bladder in this manner there is less liability to infection.

Howard Kelly of Baltimore describes a new operation which occurred to him by accident and which is especially useful when operating in the lower abdomen for appendectomy or opporectomy. It is this:

After having finished the operation in the lower abdomen for opporectomy or appendectomy through an incision in the mediate line or over the appendix, the left hand is pushed upward hugging the abdominal wall, over the omentum and the colon, as far as the liver, where the gall bladder is easily discovered in its notch.

It is his practice to squeeze the gall bladder and to note the rapid collapse showing that the cystic duct is pervious. If a stone is found, in order to remove it the gall bladder is first emptied by compression between the thumb and two fingers. This allows the stone to be hooked up by the first and second fingers to the top of the gall bladder and then firmly pressed against the abdominal wall which is thrust forward until a distinct eminence appears on the skin surface just below the margin of the ribs. Care must be taken not to allow any loop of intestines or the margin of the liver to intervene between the bladder and abdominal wall.

An incision four or five centimetres in length is made with the free right hand through the abdominal parietes over the eminence directly upon the

stone, cutting straight through layer by layer in a vertical direction.

The pressure from within keeps the tissues anemic as skin, fat and muscle are successfully divided.

The white peritoneum is recognized and on reaching this layer a little nick is made and the two edges caught with Mosquito forceps; as the peritoneal incision is made a little larger the gall bladder with the stone appears in the incision, is opened, and its edges caught with Moquito forceps as the incision is made large enough to evacuate its contents; the stone may then clear the opening suddenly and land on the floor some distance away. The wound in the gall bladder is now united by a fine silk suture beginning at the end and embracing all the coats but the mucosa. The same suture is then continued back to the starting point as a quilted suture burying the first layer. If the gall bladder is normal he returns it to the abdominal cavity without a drain; if diseased, he inserts a small drain provisionally. The abdominal wound is closed and the operation completed within a few moments after its commencement. The main points in the paper are the bacterial infection, and the immediate closing of the gall bladder, if it is normal, otherwise the insertion of a drain, and after infection has subsided or passed away, to finally close the sinus.

Professor Marmoreck, the discoverer of Antistreptococcic Serum at the Pasteur Institute, Paris, signifies his willingness to supply physicians who are especially known through their work in connection with Tuberculosis, with a certain amount of his Tuberculosis Serum for clinical tests gratis. Those who wish to take advantage of this offer may address the Pasteur Vaccine Co., 366-368 W. 11th St., New York.

## HOW I CAME TO ORIGINATE OSTEOPATHY.

(By Andrew T. Still)

[The following article published in the January issue of The Ladies' Home Journal is reproduced here in order that those members of the medical profession who do not understand the "scientific" side of osteopathy may have an opportunity to hear from the fountain head the circumstances under which it was founded. We present the article without comment, leaving our readers to form their own opinions as to its merits.—Editor.]

My first awakening to the principles which today have culminated in the science called "Osteopathy" was made when I was about ten years old. I was a boy on my father's farm in Macon county, Mo. I was subject to sick headaches, and while suffering from one of these attacks one day I was instinctively led to make a swing of my father's plowline between two trees. My head hurt too much to make swinging comfortable. I let the line down to within eight or ten inches of the ground, threw the end of a blanket on it, and lay down on the ground, using the lines for a swinging pillow. To my surprise I soon began to feel easier, and went to sleep. In a little while I got up with headache and fever gone. This discovery interested me, and after that, whenever I felt my headache spells coming on, I would "swing my neck", as I called it.

The next incident which gave me cause for thought occurred when I contracted dysentery, or flux, with copious discharges mixed with blood. There were chilly sensations, high fever, backache and cold abdomen. It seemed to me my back would break,

the misery was so great. A log was lying in my father's yard. In the effort to get comfort I threw myself across it on the small of my back and made a few twisting motions, which probably restored the misplaced bones to their normal position, for soon the pain began to leave, my abdomen began to get warm, the chilly sensation disappeared, and that was the last of the flux.

### Mill Machinery Aroused My Interest In Human Machinery.

My father, as a pioneer, was a farmer, a mill owner, a minister and a doctor. I studied and practiced medicine with him.

Pioneer life on a Western farm in those days was one in which all the inventive powers one might possess were given ample chance to show forth. Nearly all the farm machinery had to be made by hand and on the farm. There was very little to buy and less money to buy it with. My father had a grist and saw mill run by water, in the working of which I became very much interested. Later, I bought an interest in a steam sawmill, and took a course of instruction in milling machinery for practical purposes.

As I studied this mill machinery I got my first clear idea of the machinery of the human being. My mind invariably associated and compared the machinery of the mill with the machinery of the human being; with the drive-wheels, pinions, cups, arms and shafts of the human, with their forces and supplies, framework, attachment by ligament and muscle, the nerve and

blood supply. "How" and "where" the motor nerves the sensory and nutrient nerves act in their functions, their source of supply, their work done in health, in the parts obstructed, parts and principles through which they passed to perform their duties of life—all this study in human mechanics awoke with new vigor within me. I believed that something abnormal could be found which, by tolerating a temporary or permanent suspension of the blood in arteries or veins, would produce the effect which was called disease.

With this thought in mind came such questions as: What is disease? What is fever? Is fever an effect, or is it a being as is commonly described by medical authors? I took disease to be an effect, experimenting and proving the position, being sustained each time by Nature's response in the affirmative.

Early in the sixties I took a course of instruction in the Kansas City School of Physicians and Surgeons, studying such branches as were taught in the medical schools of that day. I took up the regular practice of an allopathic physician. I was called a good doctor.

**"The Proper Study of Mankind Is Man."**

During all this time I had devoted a large part of my time to the study of anatomy, which attracted me strongly. I read every book on the subject I could get hold of, but my chief source of study was the book of Nature. I found myself more and more believing that "the proper study of mankind is

man," and the best method to pursue it is to dissect and study the body itself. The skinning of wild animals in my youth brought me into contact with muscles, nerves and veins.

The skeletons of the Indians were my next study in bones, and I went on making numberless experiments with bones until I became very familiar with the entire bony structure of the human body. Finally, I tried an experiment of my own; I made a picture or chart of the bones of the whole body, then stood blindfolded, or with my back to a table. A bone would be handed to me by an assistant. I would take it in my hands and by the "feel" of it would name it and direct where it should be placed on the chart (right or left). I carried this to the extent of even the smallest bones of the hands and feet and those of the spine, until the chart was filled in complete. This I used to do over and over again. For not less than twelve months I studied bones alone, before taking up Descriptive Anatomy, because I wanted to know what a bone is and its use. I became familiar with every bone as I was with the words "father" and "mother." Of course, all this meant untiring work, and I have hardly expected my students to follow me over the entire length of this portion of my road. Nevertheless, I believe as strongly today as ever that the closer they follow this road, the better for their patients. They must study and know the exact location of every bone, nerve, fibre, muscle and organ; the origin, the course and flow of all the fluids of the body, the relation of each to the other and the function it is to perform in perpetuating life and health. In addition, they must have ability to enable them to detect the exact location of any and all obstructions to the regular movements of this grand machinery of life.



and supplement this ability with skill to remove all such obstructions.

From this study in bones I went on to the study of muscles, ligaments, tissues, arteries, veins, lymphatics and nerves.

I began now to feel that I was irresistibly headed for some road; what road I myself knew not. If one thing I was certain: I was getting farther away from the use of medicines in the treatment of ills and ails. I was a physician of the old school in name but not in fact.

I carried on my theories; I practiced them wherever I could find people who would place confidence in me, until the Civil War came on. Then I enlisted and went "to the front".

On resuming my duties as a private citizen after the war I took up again the study and research of my all-absorbing topic: how to cure disease without medicine, and on June 22, 1874, there came into my mind the first clear conception of the practical workings of what is now known as the Science of Osteopathy. This day I celebrate as its birthday.

#### **One of the First Cases I Treated.**

In the autumn of 1874 I was given a chance to try my ideas on a case of flux. I was walking with a friend on the streets of Macon, Mo., in which town I was visiting, when I noticed in advance of us a woman with three children. I called my friend's attention to fresh blood that had dripped along the street for perhaps fifty yards. We caught up with the group and discovered that the woman's little boy, about 4 years old, was sick. He had only a calico dress on, and, to my wonder and surprise, his legs and feet were covered with blood. A glance was enough to show that the mother was poor. We immediately offered our

services to help the boy home. I picked him up and placed my hand on the small of his back. I found it hot, while the abdomen was cold. The neck and the back of the head were also very warm and the face and nose very cold. This set me to reasoning, for up to that time the most I knew of flux was that it was fatal in a great many cases. I had never before asked myself the question: What is flux? I began to reason about how the spinal cord receive their power and motion, but that gave no clew to flux. Beginning at the base of the child's brain, I found rigid and loose places in the muscles and ligaments of the whole spine, while the lumbar portion was very much congested and rigid. The thought came to me, like a flash, that there might be a strain or some partial dislocation of the bones of the spine or ribs, and that by pressure I could push some of the hot to the cold places, and by so doing adjust the bones and set free the nerve and blood supply to the bowels. On this basis of reasoning I treated the child's spine, and told the mother to report the next day. She came the next morning with the news that her child was well.

There were many cases of flux in the town at that time and shortly after, and the mother telling of the cure of the child brought a number of cases to me. I cured them all by my own method and without drugs. These began to stir up comment, and I soon found myself the object of curiosity and criticism.

#### **Why I Started the American School of Osteopathy.**

Another case which I was asked to see brought upon me still further criticism. A young woman was suffering with nervous prostration. All hope had been given up by the doctors, and

the family was told. After a number of medical councils her father came to me and said: "The doctors say my daughter cannot live. Will you step in and look at her?" I found the young woman in bed, and from the twisted manner in which her head lay I suspected a partial dislocation of the neck. On examination I found this to be true—one of the upper bones of her neck was slipped to one side, shutting off, by pressure, the vertebral artery on its way to supply the brain. In four hours after I had carefully adjusted the bones of her neck she was up and out of bed.

I employed the best talent that I could find to teach them anatomy, physiology and chemistry, teaching them, myself, the principles and practice of my own science. After my school had been in running order a short time others became interested and asked permission to join, and the class increased in numbers. At the end of the first year I had some students who were able to help me in a way, and in the course of two years I really had assistance. This was the origin of what is known today as the American School of Osteopathy.

With the origination of the school came, of course, the necessity of a name to designate the science, and I chose "Osteopathy." I reasoned that the bone, "osteon," was the starting point from which I was to ascertain the cause of pathological conditions, and I combined the "osteo" with "pathy."

So "Osteopathy," sketched briefly, was launched upon the world.

#### Now What, Really, Is Osteopathy?

Many people naturally ask: What is Osteopathy?

Osteopathy is simply this: The law of human life is absolute, and I be-

lieve that God has placed the remedy for every disease within the material house in which the spirit of life dwells. I believe that the Maker of man has deposited in some part or throughout the whole system of the human body drugs in abundance to cure all infirmities; that all the remedies necessary to health are compounded within the human body. They can be administered by adjusting the body in such manner that the remedies may naturally associate themselves together. And I have never failed to find all these remedies. At times some seemed to be out of reach, but by a close study I always found them. So I hold that man should study and use only the drugs that are found in his own drug store—that is, in his own body.

Osteopathy is, then, a science built upon this principle; that man is a machine, needing, when diseased, an expert mechanical engineer, to adjust its both mental and physical, of the engineer, or Osteopath, who comes to correct the abnormal conditions of the human body and restore them to the normal. Of course, "normal" does not simply mean a readjustment of bones to a normal position in order that muscles and ligaments may with freedom play in their allotted places. Beyond all this lies the still greater question to be solved: How and when to apply the touch which sets free the chemicals of life as Nature designs?

An Osteopath is only a human engineer who should understand all the laws governing the human engine and thereby master disease.

Osteopathy absolutely differs from massage. The definition to "massage" is maso, to knead; shampooing of the body by special manipulations, such as kneading, tapping, stroking, etc. The masseur rubs and kneads the muscles

to increase the circulation. The Osteopath never rubs. He takes off any pressure on blood vessels or nerves by the adjustment of any displacement, whether it be of a bone, cartilage, ligament, tendon, muscles, or even of the fascia which enfolds all structures; also by relaxing any contracture of muscle or ligament due to displacements, to drafts causing colds, to overwork or nerve exhaustion. The Osteopath knows the various nerve centers and how to treat them, in order that the vasomotor nerves can act upon the blood vessels, bringing about in a physiological manner a normal heart action and freeing up the channels to and from the heart. The Osteopath deals always with causes, has no "rules of action," as such, but applies reason to each case according to the conditions presented, treating no two cases quite alike. He knows from past experiences that the effect seen is produced by a cause with which he must deal in order to give relief.

The Osteopath is a physician. The masseur does not take the responsibility of the full charge of a diseased condition, but works under the direction of a physician, and has to do with effects applying by rote to the body so much rubbing, so much stroking, so much tapping, so much kneading, etc., there being definite rules laid down applicable to general cases.

Next Annual Meeting, Albuquerque, September 2nd and 3rd. Don't fail to attend.

#### MARRIAGES.

Dr. George C. Bryan, Alamogordo, to Miss Laura June Bishop, Des Moines, at Des Moines, Iowa, April 15, 1908.

Next Annual Meeting, Albuquerque, September 2nd and 3rd. Don't fail to attend.

#### NOTES.

Dr. John B. Murphy has resigned as Professor of Surgery and co-head of the Department in Rush Medical College and has accepted the Professorship of surgery and head of the department in Northwestern University Medical School and position of attending surgeon at Mercy Hospital.

Dr. A. W. Meyer of the University of Minnesota and formerly of Johns Hopkins has accepted the professorship of Anatomy in Northwestern University Medical School.

Dr. A. N. Richards of the College of Physicians and Surgeons of New York City has been appointed Professor of Pharmacology in Northwestern University Medical School.

#### APHORISMS.

Look—(before you prescribe Lachesis) at the neck of a patient who complains that he cannot bear a tight collar—you may see a *goitre*.

Look—into the nose of a patient who says he has chronic catarrh—you may see a *polypus* or *hypertrophied turbinate*.

Look—into the eyes of a patient who complains of motes disturbing his vision—you may see a beginning *cataract*.



## CORRESPONDENCE.

March 25, 1908.

G. S. McLandress, M. D.,  
Albuquerque, N. M.

Dear Doctor:—I herewith enclose you a letter to the N. Y. Life. This letter is self-explanatory. This is my first opportunity.

Very truly yours,

S. D. SWOPE.

March 25, 1908.

New York Life Insurance Co.,  
New York.

Dear Sirs:—I herewith return to you a check for three dollars which you tender in payment for the examination of C. J. Kelley.

At the last meeting of the New Mexico Medical Society, the following resolution was passed: "Resolved, That it is unprofessional to accept less than five dollars for a regular life insurance examination, and that in future the members of this association shall consider that amount a reasonable and just fee for such services.

I am in hearty accord with this resolution. I have been an examiner for this company for twenty years.

Respt.,

S. D. SWOPE.

Next Annual Meeting, Albuquerque, September 2nd and 3rd. Don't fail to attend.

## BOOKS RECEIVED.

Mortality Statistics, 1906. Department of Commerce and Labor, Bureau of the Census. S. N. D. North Director. Seventh Annual Report. Pp. 480. Washington: Government Printing Office, 1908.

Transactions, Medical Association of Georgia, 1907.

Transactions, Utah State Medical Association, 1907.

Transactions, Arizona Medical Association, 1906-1907.

Next Annual Meeting, Albuquerque, September 2nd and 3rd. Don't fail to attend.

## BOOK REVIEW.

**SYPHILIS.** A Treatise for Practitioners, by Edward L. Keyes, Jr., M. D., Clinical Professor of G-U Surgery, New York Polyclinic Medical School and Hospital; Lecturer on Surgery Cornell University Medical School, etc. D. Appleton and Company, Publishers, New York.

The most complete and valuable treatise upon Syphilis yet written, representing conclusions drawn from the experience of records of 2,500 cases of Syphilis occurring in the practice of the writer, his father and his father's teacher.

The experimental work of Metschenikoff, Nisser, Roux and others in the production of Syphilis in monkeys is reviewed and attention is drawn to the most important conclusions that "Syphilitic secretions cease to be infectious after 12 to 24 hours and much sooner when dry, and that this probably explains why we do not all get infected from objects which have been in the hands of Syphilitics." It is further pointed out that the virus of Syphilis having been brought in contact with an abrasion on the skin of a non-syphilitic, the only measure of prophylaxis consists in the application of a strong mercurial ointment to the spot of inoculation within one hour.

Regarding the "Probability and Possibility of Infection" the writer wisely states "that nothing is certain in Syphilis except its uncertainty." Exposure does not necessarily imply infection; the physician who has the confidence of his patients will occasionally come upon cases where exposure even repeated exposure, has not resulted in infection, etc.

Syphilis and Marriage is well discussed and it is asserted "that matrimony is often safe and sometimes justifiable at the end of three years, but unless the sociable element at stake are very great it is more prudent to follow the rule that **marriage of a syphilitic is permissible only after five years, during the last two of which he has been without symptoms and without treatment.**

Two of the most interesting chapters in the work are upon "Transmission of Syphilis" and "Syphilitic Inheritance."

Symptoms, Diagnosis and Complications are thoroughly discussed.

The chapters on Treatment are very complete and clear, every known treatment is considered, the large number of cases treated affording ample opportunity to determine the worth of each.

The work is well illustrated with a large number of plates, seven of which are colored.

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Upon his arrival he was placed in the ward and one of the nurses put a thermometer in his mouth to take his temperature. Presently, when the doctor made his rounds, he said:

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"I feels right tol'ble, sar."

"Have you had anything to eat?"

"Yassar."

"What did you have?"

"A lady done gimme a piece of glass ter suck, sar."

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## CONTENTS

Dr. G. K. Angle, President.....	3
Minutes of the House of Delegates.....	4
Minutes of the General Sessions.....	7
The New Mexico Medical Society; Some Duties and Opportunities, Dr. R. E. McBride.....	10
Vaccine Therapy: Its Value to the General Practitioner, Dr. Robert Smart .....	15
Miscellaneous .....	23

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OF THE

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**NEW MEXICO MEDICAL SOCIETY.****Officers.**

President, G. K. Angle,.....Silver City  
First Vice-Pres., J. W. Elder...Albuquerque  
Second Vice-Pres., F. T. B. Fest. E. Las Vegas  
Third Vice-Pres., R. L. Bradley...Roswell  
Secretary, G. S. McLandress...Albuquerque  
Treasurer, C. G. Duncan.....Socorro  
Council: W. R. Tipton.....Las Vegas  
G. W. Harrison.....Albuquerque  
S. D. Swope.....Deming

**Affiliated Societies.**

Las Vegas, Bernalillo County, Chaves County,  
Grant County, Dona Ana County, Luna  
County, Otero County, Eddy County, Quay  
County.

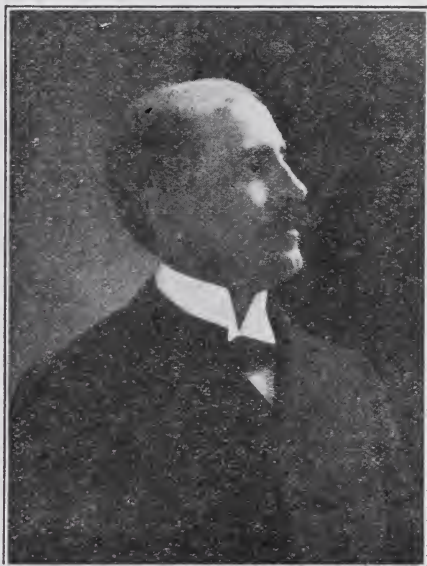
**DR. G. K. ANGLE,**

Newly Elected President of the New Mexico  
Medical Society.

A little more than 40 years ago, in the village of Hainesville, in the county of Sussex, New Jersey, was born a boy whom the most far-seeing prophet would scarcely have connected with the then almost unknown Territory of New Mexico, but Fate had planned that he should, in the year 1908, be called by his professional brethren to the presidency of the Medical Society of the Territory, to become in 1909, as we confidently expect, the first president of the Medical Society of the State of New Mexico.

While yet a small child, Easton, Pa., became his home, and there, under the shadow of Lafayette College, its campus his playground, his boyhood was

spent, and later, in the college, under the personal supervision of Professor Coffin, his brother-in-law, he laid the foundation of that broad, liberal, thorough education which makes him to-day a scholar in the widest, truest sense. While in college he took an active part, in its social and other interests, aside from those which were purely scholastic. The fraternity with



DR. G. K. ANGLE,  
President New Mexico Medical Society.

which he was connected was the Delta Upsilon, Gov. Hughes, of New York having been a member of the committee which inducted him into its mysteries.

After receiving his degree, he spent some time in study at the University of Colorado, going from there to Bellevue Hospital Medical College, where he made a good record as a student, and received his degree of Doctor of Medicine in 1891. After his graduation he practiced for a number of years very successfully in his home town of Easton, coming to Silver City, N. M., three years ago, to assist his old-time



friend, Dr. Lane, when Dr. Lane's health became such that he could no longer attend properly to his large practice.

Dr. Geo. K. Angle, for he it is to whom the above refers, is recognized by those who know him best to be a modest, unassuming gentleman, a talented scholar, and a careful, conscientious and experienced physician and surgeon. He is careful in his investigations, decided in his opinions, frank in expressing them and firm in standing by them; a good friend, a good neighbor and a good man, and his colleagues in Grant County, while they recognize the honor that has been done to Dr. Angle and to the Grant County Medical Society by his elevation to the highest place in the gift of the Society, feel also that the Territorial Society has equally honored itself by choosing him as its official head.

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#### MINUTES OF THE TWENTY-SEVENTH ANNUAL SESSION

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#### MINUTES OF THE HOUSE OF DELEGATES

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New Mexico Medical Society, Albuquerque,  
September 2nd and 3rd, 1908.

The House of Delegates was called to order by President McBride, the Secretary and the following delegates being present:

Bernalillo County Medical Society—Dr. P. G. Cornish, Dr. Taylor-Goodman, Dr. W. W. Spargo.

Luna County Medical Society—Dr. S. D. Swope.

Grant County Medical Society—Dr. S. A. Millken.

Chavez County Medical Society—Dr. R. L. Bradley.

Las Vegas Medical Society—Dr. F. T. B. Fest.

Dona Ana County Medical Society—No delegate.

Otero County Medical Society—No delegate.

Eddy County Medical Society—No delegate.

Quay County Medical Society—No delegate.

The credentials of the above delegates were approved.

The minutes of the previous session, held at Las Cruces, N. M., May 8th and 9th, 1907, were then read and it was moved by Dr. W. R. Tipton and supported by Dr. G. W. Harrison that they stand approved as read. The motion carried.

President McBride then spoke of the funds of the Society being conserved, using the money now being spent for the annual banquet for organizing the profession, visiting County Societies and to make the banquet a subscription affair in the future.

Dr. S. D. Swope suggested the advisability of appointing a traveling organizer; one who had time to spend four or five days in certain counties if necessary. It is estimated that the cost of our annual banquet would be sufficient to cover expense.

The report of the secretary was next taken up and it was moved and supported that the report be received and filed and the bill referred to the Council for action. Carried.

It was moved by Dr. Taylor Goodman and supported by Dr. S. D. Swope that all guests at the meeting be invited to the banquet, subject to the discretion of the President. Carried.

The House then adjourned until 5 o'clock p. m.

#### Wednesday Evening, 5 O'clock.

The House was called to order by President McBride, all delegates who attended the morning session being present.

It was moved by Dr. Taylor-Goodman and supported by Dr. W. W. Spargo that the report on applications

as submitted by the Council be approved. Carried.

The following are the applicants:

Dr. Marcellus McCreary, Magdalena, N. M.; Dr. A. H. Faith, Clovis, N. M.; Dr. F. J. Given, Hillsboro, N. M.; Dr. F. C. Diver, Dawson, N. M.; Dr. R. C. Dryden, Parsons, N. M.; Dr. V. S. Cheney, Kettner, N. M.; Dr. W. D. Sunderland, Estancia, N. M.

A petition from Chavez County Medical Society, recommending that the name of Dr. R. L. Bradley be placed on the list of eligibles for appointment on the Board of Health was then read.

It was moved by Dr. G. W. Harrison and supported by Dr. W. R. Tipton, that the petition be filed and the Chavez County Society be advised that the list is now complete. Carried.

The House then adjourned to meet Thursday morning, September 3rd.

**Thursday Morning, Sept. 3, 1908.**

The House opened with all delegates present.

The minutes of the preceeding meetings of the House of Delegates were read and on motion were adopted as read.

Election of officers then being in order the House proceeded to name the officers for the ensuing year; as a result the following were elected to serve:

President—Dr. G. K. Angle, Silver City, N. M.

First Vice-President—Dr. J. W. Elder, Albuquerque, N. M.

Second Vice-President—Dr. F. T. Fest, E. Las Vegas, N. M.

Third Vice-President—Dr. R. L. Bradley, Roswell, N. M.

Secretary-Editor—Dr. G. S. McLandress, Albuquerque (re-elected).

Treasurer—Dr. C. C. Duncan, Socorro, N. M. (re-elected).

Councillor to succeed Dr. W. R. Tipton (elected for three years)—Dr. W. R. Tipton (re-elected).

Councillors holding over—Dr. G. W. Harrison, term expires 1910, Dr. S. D. Swope, term expires 1909.

Committee on Scientific Work—Dr. E. S. Bullock, Silver City, Chairman; Dr. G. S. McLandress (Secretary), Dr. E. B. Shaw, E. Las Vegas.

Committee on Public Policy and Legislation—Dr. G. W. Harrison, Albuquerque, Chairman; Dr. C. G. Duncan, Socorro; Dr. H. M. Smith, E. Las Vegas, President (ex-officio) Secretary (ex-officio).

Delegate to American Medical Association—Dr. R. E. McBride, Las Cruces.

Alternate Delegate, Medical Association—Dr. W. H. Burr, Gallup.

It was moved by Dr. S. D. Swope and supported by Dr. W. R. Tipton that the House of Delegates here in session recommend to the General Session of the New Mexico Medical Society that the office of Organizer be created, the abolishing of the annual banquet except upon subscription, and that the funds used by said Organizer be subject to the discretion of the Council. This motion carried.

Resolutions on deaths of Drs. B. D. Black and Karl D. Wood were then read and adopted.

Roswell was then chosen by unanimous vote as the meeting place for the 28th annual session.

The House then adjourned.

**Final Meeting, Thursday, Sept. 3, 1908.**

The House was called to order by President McBride, all delegates being present.

It was moved by Dr. G. W. Harrison and supported by Dr. S. D. Swope that the accounts of the Secretary and Treasurer as read be paid. The motion carried.

It was moved by Dr. S. D. Swope and supported by Dr. G. W. Harrison that the present incumbents be re-elected as Associate Editors of the Journal and the Secretary was instructed to cast the ballot in accordance with the resolution. Carried.

At this time Dr. C. G. Duncan, Treasurer, entered and stated that in his opinion the bond of the Treasurer should be increased.

After discussion it was moved by Dr. W. R. Tipton and supported by Dr. G. W. Harrison that the bond of the Treasurer be made double the amount of collections. The motion was carried and the Treasurer so informed.

It was moved by Dr. W. R. Tipton and supported by Dr. W. W. Spargo that it is the sense of this House of Delegates that any member is in arrears at the end of one year and stands suspended at the end of two years upon failure to pay dues. Carried.

It was moved by Dr. W. R. Tipton and supported by Dr. S. D. Swope that the recommendations in the address of President McBride be endorsed and referred to Committee on Public Policy and Legislation. Carried.

There being no further business the House of Delegates of the 27th annual session of the New Mexico Medical Society then adjourned, sine die.

(Signed) G. S. McLANDRESS,

Secretary.

To the President and Members of the House of Delegates of the New Mexico Medical Society:

Gentlemen:—In compliance with the requirements, the Secretary begs leave to submit the following report:

In reviewing the membership list we find as usual some variations. Some counties have gained, some have lost and others are stationary. Up to the first of September the membership of the Territorial Society stands as follows:

Las Vegas Medical Society.....	18
Bernalillo County Society.....	37
Chavez County .....	12
Otero County .....	11
Luna County .....	5
Dona Ana County .....	9
Grant County .....	12
Quay County .....	11
Eddy County .....	11

126

Members outside Counties..... 15

141

Two new county societies have been organized during the past year, viz: Eddy County with 11 members, and Quay County with 11 members. Both new County Societies have live secretaries and we predict a constantly increasing membership in that part of the Territory.

Santa Fe and Colfax Counties have yet to be organized, there being enough practitioners in each to maintain a healthy organization.

The card index has been added to considerably during the year, but it has been almost impossible to get answers from the numerous new men who have located in the Territory. It is estimated that we have some 350 practitioners in New Mexico and every address available has been jotted down and a record blank together with an application for membership blank sent to each. It is to be regretted that the records of the Licensing Board are not available to the secretary of this Society. In such event more precise data could be kept. There is a great number of newly licensed men who are most desirable as members of this society and each of us should make an effort to bring in those within our reach.

It becomes my duty to report the death of Dr. B. D. Black of E. Las Vegas, and Dr. Karl D. Wood of Silver City, as having occurred since our last meeting.

In April of this year, the Council on Medical Education of the A. M. A. held its fourth annual conference at



Chicago, and the President appointed Dr. G. W. Harrison to represent this Society; Dr. Harrison was notified, accepted and was present at the meeting.

The publication of the Journal has proceeded quite regularly. Since our last meeting five issues have been printed, June, September, and December, 1907, and March and June, 1908. As in former years the same policy is adhered to in refusing advertising space to manufacturers of quack remedies or to anything not in accord with the principles of ethics as understood by our profession.

On account of the money stringency and the conservative methods pursued by business houses throughout the country as a consequence it has been hard to add to our advertising account, and I regret to announce that the Journal has been carrying a number of dead matter ads; this policy is maintained because of the appearance of the advertising pages to prospective advertisers, and awaits your approval or disapproval.

During the past year 21 original articles appeared; 128 pages of reading matter and 52 pages of advertising matter.

I am glad to report that all bills against the Journal have been paid and we have to our credit at least \$180 worth of collectable advertising accounts.

In spite of our inability to procure new advertising contracts, and in spite of the money stringency our Journal is prosperous and so far it has not been necessary to call upon the Society for a dollar for its maintainance.

The Secretary herewith presents his account and asks favorable action thereon.

Respectfully submitted,

G. S. McLANDRESS,

Secretary.

## MINUTES OF THE GENERAL SESSIONS

Of the New Mexico Medical Association, Albuquerque, New Mexico, Sept. 2nd and 3rd, 1908.

Wednesday Morning, Sept. 2nd, 1908.

The meeting was called to order by President R. E. McBride of Las Cruces.

The Reverend Father Mandalari was then asked to invoke divine guidance, the members standing.

The address of welcome was delivered by Dr. J. H. Wroth of Albuquerque who was delegated to act by Mayor Felix Lester who was unable to attend. In a few choice words the visitors were made welcome and the keys of the city metaphorically handed to the members of the New Mexico Medical Society during their stay. The response to the address of welcome was delivered by Dr. W. H. Burr of Gallup, New Mexico.

President McBride then delivered his annual address entitled, "The New Mexico Medical Society; Some Duties and Opportunities." Herewith is published this able address verbatim, and it is conceded that, should the recommendations therein obtain, Dr. McBride will go down in the history of this Society as its greatest exponent of medical advancement and righteousness.

It was moved by Dr. Wroth and seconded by Dr. Duncan that the recommendations contained in the President's address be referred to the Council for action and reported in general session Thursday morning. Carried.

The report of Dr. C. G. Duncan, the Treasurer, was then read, showing a balance of \$572.22 in the treasury of the Society. The report was referred to the Council.

Dr. G. W. Harrison, delegate to Council on Medical Legislation of

American Medical Association, then gave a verbal report.

This was followed by a verbal report of the delegate to the American Medical Association, Dr. W. R. Tipton of East Las Vegas.

A motion to adjourn until one o'clock p. m., was carried.

The meeting was opened at 1:30 p. m., by President McBride, calling attention to Section 1, Chapter 10 of the Constitution and By-Laws relative to time allowed for reading and discussion of papers.

The first paper of the scientific program entitled "Traumatic Lesions of the Spinal Cord" was read by Dr. John W. Colbert of Albuquerque. The subject was well covered and was discussed by Dr. G. K. Angle of Silver City.

"The Eosinophil and Opsonic Index" was the title of the second paper by S. D. Swope of Deming. This was an interesting paper from many standpoints and was followed by a paper entitled "Vaccine Therapy—Its Value to the General Practitioner" by Dr. Robert Smart of Albuquerque. These papers were discussed jointly by Drs. J. A. Massie of Santa Fe and F. T. B. Fest of East Las Vegas.

Dr. James Vance of El Paso, Texas, then read an instructive paper entitled "After Treatment of Abdominal Section" which was thoroughly discussed by Drs. J. H. Wroth of Albuquerque, W. R. Tipton, East Las Vegas, and P. G. Cornish of Albuquerque.

President McBride then introduced Dr. Fleming Jones, of British New Guinea, who spoke interestingly on medical conditions in that far away South Sea Island.

A paper entitled "The Sequelae of Appendiceal and Puerperal Infections, with notes on Appendicitis in Children" by Dr. William H. Burr of Gallup was

then read and discussed by Drs. S. D. Swope, Deming, and James Vance, El Paso.

An invitation was then extended all visiting physicians to the annual banquet by President McBride, after which it was moved that the meeting adjourn until 9 a. m., Thursday, September 3rd.

#### Thursday Morning, Sept. 3rd, 1908.

The meeting was called to order at 9:30 a. m., by President McBride.

It was moved by Dr. J. H. Wroth, Albuquerque, and supported by Dr. W. R. Tipton, East Las Vegas, that the office of Organizer be created for the purpose of more thoroughly organizing the profession of the Territory, visiting county societies, etc. The expenses of such officer to be paid by the Society subject to the action of the Council; and that in the future the annual banquet be managed by subscription. This motion was discussed by Drs. Swope, Harrison and Hope and was amended by adding that the power of naming the organizer be in the Council and officers of the Society. The motion being put to the Society was carried as amended.

It was moved by Dr. G. W. Harrison and supported by Dr. W. R. Tipton that the recommendations embodied in the presidential address be endorsed. This motion was carried unanimously.

It was moved by Dr. J. H. Wroth and supported by Dr. C. G. Duncan that all the papers appearing on the program by men who had been unable to come to the meeting be read by title and the authors requested to send their productions to the Journal for publication. This motion carried.

A well written paper entitled "Routine Examinations of Eye, Ear, Nose and Throat of School Children" was read by Dr. C. S. Losey of East Las Vegas and was discussed by Drs. Shadrach, Tull, Fest, Hope, Harrison,

Burton, Strong and Lukens. It was suggested by Drs. Fest and Hope that this paper be made a basis for some action for Committee on Public Policy and Legislation.

The next paper entitled "Routine Examination of School Children for Oral Defects" by Dr. E. J. Alger of Albuquerque was then read. This paper was well received and enlivened discussion by Drs. Patchin, Angle, Burr, Reidy, Cornish, Hope, Pearce, Lukens, Sewell, Fest, Rice and Burton.

Dr. Andrew Wade Morton of San Francisco then read an interesting paper on "Spinal Analgesia" in which a review of cases so anesthetized was given. The subject was then discussed by Drs. Elder, Swope and Vance.

It was moved and supported that the thanks of this Society be extended Dr. Morton for the excellent exposition of his method in Spinal Analgesia and for favoring us with his presence at this meeting. This motion was carried unanimously.

It was moved and supported that we adjourn to meet at the operating room of the Santa Fe Pacific Hospital to witness demonstrations of Spinal Analgesia by Dr. Morton. Carried.

The first paper of the afternoon was then read by Dr. G. K. Angle of Silver City and was entitled "A Report of Five Cases of Milk Sickness." This disease which has recently been found in our Territory was well discussed in this paper and debated by Drs. Milliken and Welsh.

A most thorough and scientific paper was then read by Dr. F. T. B. Fest of East Las Vegas, entitled "The So-Called Bacillus Tuberculosis—A Critical Review" and was discussed by Drs. Colbert and Spargo.

Dr. S. G. Sewell of Albuquerque then read an excellent paper entitled "Diet and Rest in Pulmonary Tuberculosis"

which was discussed by Drs. Hope and Harrison.

The next paper entitled "Exercise in Pulmonary Tuberculosis" was read by Dr. S. A. Milliken of Silver City. This important subject was ably handled by Dr. Milliken and discussed by Drs. Hope and Sewell.

It was moved and supported that we adjourn to meet at 8 o'clock p. m. Carried.

Thursday Evening, Sept. 3rd, 1908.

The meeting was called to order at this hour with President McBride in the chair.

It was moved by Dr. G. W. Harrison and supported by Dr. W. R. Tipton that Dr. J. P. Kaster of Topeka be made an honorary member of this Society. The motion was carried and the Secretary instructed to notify Dr. Kaster.

Dr. R. L. Bradley of Roswell then read a splendid paper entitled "Diagnosis and Surgical Treatment of Common Diseases of the Gall Bladder." This paper was well discussed by Drs. Wroth, Morton, Vance and Elder.

Dr. M. K. Wylder of Albuquerque then read a paper entitled "Report of Case of Traumatic Epilepsy—Operation—Recovery." Dr. Wylder's paper and report were discussed by Drs. Swope, Morton and Cornish.

Dr. J. A. Reidy of Albuquerque gave a report of a case of "Malignant Oedema," which was thoroughly discussed by Drs. Rice, Wylder, Cornish, Pearce, Bradley, Swope and Vance.

Following the reading of the last paper came the introduction and presentation of president-elect, Dr. G. K. Angle of Silver City. Dr. Angle then addressed the members, expressing his thanks to the Society and his determination to make the coming year a successful one in the history of the New Mexico Medical Society.



Dr. J. W. Elder, Albuquerque, was called upon and thanked the Society for honoring him with the first vice-presidency.

It was moved by Dr. McBride and supported by Dr. Wroth that this Society do make Dr. Andrew Wade Morton of San Francisco an honorary member. This motion was carried unanimously.

It was moved by Dr. Wroth and supported by Dr. Swope that this Society do make Dr. James Vance of El Paso an honorary member. Motion carried unanimously.

It was moved by Dr. Wroth and supported by Dr. Elder that this Society do make Dr. James B. Cutter of Los Angeles an honorary member. Motion carried unanimously.

There being no further business it was moved and supported that we adjourn subject to the call of the Council.

G. S. McLANDRESS,  
Secretary.

Whereas: The New Mexico Medical Society is indebted to the Commercial Club for this commodious and comfortable place of meeting, To the Bernalillo County Medical Society for their successful efforts for the entertainment of visiting members, To the Committee of Arrangements for the magnificent effect of their efforts, therefore,

Be it Resolved, That the thanks of the New Mexico Medical Society be and hereby is, tendered to these organizations and that a copy of these resolutions be spread upon the minute book of this Society.

Whereas: The All Wise Ruler of the universe has removed from their labors upon this earthly sphere our honored and esteemed co-workers, Dr. B. D. Black of East Las Vegas, N. M.,

and Dr. Karl D. Wood of Silver City N. M., therefore,

Be it Resolved, That in the death of these honored members this Society has suffered a material loss and the medical profession has suffered the loss of two able exponents of the healing art. That a copy of these resolutions be spread upon the minute book of this Society, published in the Journal of the Society and that a copy of same be sent to the nearest surviving relations of the deceased.

(Signed)

S. D. SWOPE,  
Chairman of Com.

#### THE NEW MEXICO MEDICAL SOCIETY: SOME DUTIES AND OPPORTUNITIES.

By Dr. R. E. McBride, Las Cruces.

Annual address of the president at the 27th annual meeting, Albuquerque, September 2nd, 1908:

Gentlemen:—

It is a great pleasure for me to greet you this morning in the name of organized medicine. The New Mexico Medical Society is an organization over which any one might feel proud to preside and I am not unconscious of the honor you conferred in electing me to this position. I am deeply grateful and I thank you.

Our present membership, including county societies, numbers 158. During the past year two new counties have been organized. These are Quay county with a membership of 11 and Eddy county with a membership of 11. To the efforts of our able secretary, Dr. G. S. McLandress, may be credited these organizations as it was through his efforts that the organizations were perfected.

I greatly regret that I was unable to officially visit each one of the component county societies during my term of office, but circumstances over which

I had no control prevented this. I have outlined a plan and presented it to the house of delegates for consideration whereby future presidents may be permitted to more readily pay an annual official visit to such societies as may need help and assistance as well as to such counties where an organization seems possible. I believe that the president of the Territorial organization should make an annual visit to the component county societies and this at the expense of the Territorial organization. This could be accomplished by my plan which I trust the House of Delegates will look upon with enough favor to report it to the general meeting for consideration and discussion.

To us in this favored section of our common country is given a most wonderful opportunity to work out some of the problems that are baffling medical science, notably in tuberculosis. With the wealth of material that annually comes within our reach it seems to me that there should be some concerted action on the part of this Society looking to the establishment of a thoroughly equipped laboratory in charge of some competent man and having for its specific object the solving of some of those numerous problems which are holding the attention of scientists the world over. The search for a specific for tuberculosis is a work worthy of the best among us and there seems to me to be no just and good reason why this work should not be carried on in this Territory. Whether this be done by private subscription or by governmental aid and private subscription combined is a question, but it appears to me that there is a great opportunity presented to us and we should not overlook it. I would invite a thorough discussion of this question at some time during this meeting with a view to naming a committee to carefully ex-

amine into this matter and to report a year hence. The number of ethically conducted institutions in the neighborhood might offer some starting point, for the establishment of a research laboratory within the confines of the Territory would soon strengthen our knowledge along other lines of work and be productive of many good results. I leave this suggestion with you, trusting that you will give it careful thought and attention.

Medical education and just medical laws are subjects upon which opinions differ widely and in approaching them I am fully conscious of these differences in ideas but they are, nevertheless, of vital importance and should receive some attention at our hands.

At the last annual conference of the Council on Medical Education of the American Medical Association held in Chicago during last April, our Society was represented by Dr. G. W. Harrison of Albuquerque. I here take great pleasure in thanking Dr. Harrison for his unselfishness in attending this and other meetings in the interest of our Society at his personal expense.

At this gathering a free discussion of a number of most important subjects relating to medical laws and examining boards as well as to medical education in general was entered into. Some most interesting information was disclosed, such as the fact that the United States is supporting forty-eight per cent of the medical institutions of learning of the world, or one hundred and sixty-one medical colleges, thirty-nine of which are below the standard. Another fact is disclosed in the information that medical education in the United States, as compared with European schools, is deficient both in preliminary requirements and in the length of the medical courses. The report goes on to say: "In this country

of great wealth and great population, and of high average intelligence, we can no longer be satisfied with our present standards of medical education, which are much below those of Germany, France, and England; nor should we be satisfied with any except the highest and best. The great advance in the sciences in recent years has created the necessity for a much broader and more thorough education, both preliminary and medical, for the physician equipped to practice modern medicine."

The consensus of opinion, as expressed in the address of the chairman of the convention, seemed to be that in the matter of licensing there should be

1. A single board.
2. A provision for reciprocity, properly safeguarded and administered.
3. The board should have power to inspect the medical colleges and refuse recognition to such as are disreputable.
4. There should be at least a four-year high school education.
5. A degree should be required before a candidate can take a state board examination.

Now, with this proposed standard before us let us compare our own law.

We have a single medical board.

We have a reciprocity provision.

We have power to deny recognition to graduates of colleges whose standing is doubtful.

We require a standard four-year high school education.

We require graduation of all applicants.

Our present law seems, therefore, to be a good one. It more nearly approximates the standard than some of the laws of the more thickly settled eastern states. It may be improved in one or two points, but so far as I have been able to learn there have been no ill results following its administration. Our legislative committee should be requested to meet with a committee

from the Territorial Board of Health with a view to discussing needed changes, if any, for the purpose of presenting their recommendations to the coming session of the legislature for enactment into law.

At some time during this session steps should be taken to provide a list of recommendations for appointment on the Board of Health as required by the first section of the law. While the Governor is under no obligations to appoint his board from the names upon this list I believe that he will be glad to have the recommendations before him for his information.

Another thought here occurs. Has not the time arrived when the Board of Health should be relieved of its duties as a medical examining board? Are we not far enough along now to have two separate and distinct boards? The Board of Medical Examiners, to be appointed from recommendations furnished by the New Mexico Medical Society should be concerned solely with the passing upon the fitness of candidates presenting themselves for examination and seeing to it that there is no encroachment upon the rights of legitimate medicine. They should receive an allowance for their work sufficient to cover actual expenses incurred in their work and in attending meetings.

The Board of Health should have entire charge and control of the public health and all questions bearing thereon. There should be a representative of this Board in each county paid a salary sufficient to warrant his attending to his work. This salary need not be large—say fifty or sixty dollars a month—and should be paid by the county. The rapidly growing population of the Territory is creating problems that the local health officers are expected to solve and under our pres-



ent system the power of the local health officer is limited and doubtful even in its limited state. A good "cussing" is usually the reward for an attempt to perform conscientious duty in this respect, and the lack of funds with which to accomplish results is a great drawback. It makes it almost impossible to do anything in the way of bettering sanitary conditions and other necessary requirements drag behind as well. There is little incentive to actively enforcing the health law and seldom any assistance from the public at large. A paid county health officer with duties and powers specifically defined by law could accomplish much, particularly were the law to indicate the ways and means of providing funds. The spreading of contagious diseases could be stopped, particularly in the case of neighboring counties while the general sanitary and hygienic conditions of the people could be improved. There is much to commend this course and I believe the Society could well spend time for a full discussion of this suggestion which I earnestly commend to your consideration. The army of tubercular invalids should be brought under some sort of control; promiscuous expectoration should be stopped and every possible means taken to prevent these unfortunates from becoming a danger to the population. I would not have you understand that I advocate the plan that forbids them the right to search for health in this glorious climate, but I most assuredly do believe that in return for the health-giving properties of our glorious climate they should be willing to submit to some legal regulation. Just what, is the question, but if we put our heads together I am sure that we can evolve some plan whereby they may be made comfortable and yet not be a source of danger. Disinfection and fumigation of living quarters

should be enforced. Surroundings should be made as sanitary as modern science can make them and notification or more properly speaking registration should be insisted upon. Within the past year I have seen no less than twelve cases of tuberculosis among natives traceable directly to contact with a health-seeker and it is a well known fact that when one of our native population becomes infected there is no power known that will prevent the disease taking its course. I am fully convinced that tuberculosis is spreading among the natives and we should step in and do what we can to stop it. All of this could be done by law through the representatives of the Territorial Board of Health. I therefore recommend a full and free discussion of this matter with a view to determining some fixed policy toward which we can work.

Another of the purposes of this organization is to "guard and foster the material interests of its members and to protect them from imposition." This is a most important purpose and carries with it a duty in which each individual member has a part to perform. In the first place we should not rest content until every reputable physician practicing in the Territory of New Mexico is made a member of this Society, and becomes actively identified with its work. This accomplished the rest will be easy.

The greatest drawback to the material advancement of the physician is the physician himself. There are many men—too many—even in the ranks of organized medicine who are too zealous of their own interests. They rise to heights of fancied greatness on the prostrate bodies of their abused fellow practitioner. Once a substantial organization is achieved in the Territory we may rest assured that a united

effort will succeed in elevating the standard of practice and be to our own material gain to say nothing of to the benefit of the public.

The quack is ever with us. Go where you will you will find him. New Mexico, fortunately, is reasonably free of this class of undesirable citizens. There are a few of them in the Territory, but not nearly so many as there might be. It appears to me that the remedy against "quackery" lies in education of the public to a true understanding of the business and duties of ethical medicine for this done the quack disappears for want of material upon which to work. This subject is a "big" one, too large for me at this time when moments are precious and I fear to enter into it, but mention it in passing, "Lest we forget".

Recent years and the events therein have brought the realization of a new duty to the physician. I refer to that of educating the public in the great problems of state medicine and the preservation of the public health by the prevention of disease rather than its cure. The American Medical Association has recently authorized and appointed a Board of Public Instruction. The report of this newly constituted board appeared in a recent issue of the Journal of the American Medical Association. Among other things it recommends the establishment by the various state societies of state boards of public instruction as subsidiary boards whose functions shall be to take up subjects especially adapted to their given territory. Here I shall take the liberty of quoting some passages from the address of the president of the American Medical Association, Dr. Burrell, delivered at the last annual meeting of the Association: "In what medical subjects should the public be educated? It will be better to teach thoroughly a few

important subjects than to attempt to cover too large a field. Let us not be blind to the fact that our scope of usefulness as physicians in dealing with the large disease problems depends in a great measure on the co-operation of the public. We must have intelligent co-operation to make our work as effective as may be. Tuberculosis is still the most pertinent subject on which information should be given. \* \* \*

The work already accomplished by the public in co-operation with physicians in controlling tuberculosis, ophthalmia neonatorum and scarlet fever comes to everyone's mind. The work that has been done in controlling yellow fever in Louisiana by the public and the medical profession is a striking example of educating the people as to the facts concerning disease. The various infectious diseases are obviously ones concerning which the public should be informed. The people should be educated as to the necessity of pure air, pure water and pure food: they should know the hygienic value of bathing. They should know that hospitals are provided not alone for the care of the sick poor, but that knowledge of disease may be advanced."

"Who among the public should be first educated? Those who are leaders in the community; those who are in positions of responsibility — national, state, city and town authorities, trustees of hospitals and schools—they should first be informed as to the facts concerning disease."

"What are the means by which we may reach the public? Newspaper articles on selected subjects, giving facts concerning a given disease, but not the treatment of disease, should be furnished the press."

I have quoted some of the main points in this address bearing upon this proposed Bureau of Publicity

work. The truth and nothing but the truth must be told at all times and upon all occasions so that there may be no misleading. It will be well for us to have in mind this suggestion as to a subsidiary board in this Territory working under the direction of the Territorial organization. Whether the time for its establishment is here is doubtful, but I feel that some thought should be given the matter so that when the time for action arrives we may find ourselves prepared.

The matters to which I have called your attention are but a few of what appear to me to be the most important duties of this organization as well as some of the opportunities that present themselves to us at this time. It behooves us to do our duty as an organization of medical men so that we as a profession shall "become more capable and honorable as well as more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to human life."

"There seems to be no limit to the possibilities of scientific medicine, and while philanthropists are turning to it as to the hope of humanity, philosophers see, as in some far off vision, a science from which may come in the prophetic words of the Son of Sirach, 'Peace over all the earth.'"

#### JUST AS GOOD AS EVER, TOO.

An old physician was noted for his brusque manner and old-fashioned methods. A lady called him in to treat her baby, who was slightly ailing. The doctor prescribed castor oil.

"But, doctor," protested the young mother, "castor oil is such an old-fashioned remedy."

"Madam," replied the doctor, "babies are old-fashioned things."—London Opinion.

#### VACCINE THERAPY: ITS VALUE TO THE GENERAL PRACTITIONER.\*

By Dr. Robert Smart, Albuquerque.

Mr. President and Members of the Territorial Society:

I appreciate exceedingly your courtesy in asking me to present this paper on the Vaccine therapy before your Society. The subject is one that is interesting and new; two features which have led many workers throughout the world to experiment along this line; and third and a most important factor is that in so large a majority of the cases most favorable reports have been accorded this treatment. Personally, my experience has been so limited, that I can add nothing new to the vast amount of literature which is daily accumulating upon this subject and my excuse in bringing it before you is merely to present to you briefly my conception of what, up to the present, has been accomplished and a very modest opinion as to its adaptability in general as a therapeutic agent.

For some years back the subject of immunity has been one in which the whole medical world has been engrossed and while too much praise cannot be afforded Metschnikoff and his followers for the brilliant experiments whereby they tried to substantiate their Cellular theory of Immunity, it seems all but universally believed, that there is more ground for the belief in the Humeral theory, so ably put forth by Ehrlich, Morgenroth and their followers. This statement does not in the least detract from Metschnikoff's phagocytic theory, since the recent work by Wright, Duncan and Ross, show that the phagocyte is extremely necessary in combating infection.

Briefly, the experiments of recent years show:

\* Read before the New Mexico Medical Society, Sept. 3rd, 1908.



First, that there is in normal blood certain substances, antibacterial in character, but that they exist there in insufficient amount to successfully combat infectious bacterial disease.

Second, that the cells of the organism are so constructed that in the event of infection by any specific bacteria, anti-bodies for that particular organism, by reason of the infection, are enormously increased.

Third, that after recovery from bacterial diseases the subject of the infection is for a longer or shorter period protected by these anti-bacterial substances.

Fourth, that protective inoculation against bacterial disease may be accomplished in two ways: by the injection of antitoxic sera into the infected individual, which is passive immunity; or by the injection of the specific bacteria causing the disease either dead or in attenuated cultures which gives active immunity.

Fifth, that passive immunity is quickly established but of short duration, while active immunity is more lasting but more slowly acquired.

Sixth, that the anti-bacterial substances in the blood are specific and that they may be increased artificially.

Seventh, that these substances combine chemically and in combining with the bacteria or cells of the body they follow the laws of chemical proportion.

Eighth, that it has been found possible to measure quantitatively one of these anti-bacterial substances in the blood and to be able in consequence, to measure the protection afforded in a case of infection.

Aside from the interest which attaches to the experiments by which these points, in most instances, have been proved, is the fact that they are probably the foundation of a new

science of chemistry, to be known as Biologic Chemistry; and further, they are of practical importance in that they have proved conclusively, not only, that we have at our command a method of increasing resistance against any microbic invasion but probably a method of estimating that resistance.

We may, for discussion, divide bacterial infection into four classes: first, acute infections in which the system is quickly overwhelmed by bacterial poison and rapidly killed; second, in which the infection is less severe, but general and in which the system has time to gather its forces to combat the disease and to save the integrity of the infected organism; third, those cases which might be a continuation of the second class just described in which the battle has been terrific and both sides are about exhausted and for supremacy it is merely a question of which recuperates first sufficiently to begin the attack; and fourth, those cases of chronic local infections which are not so severe as to call forth a general systematic fight, but in which Nature confines her efforts to a walling off process to prevent further or general infection.

In the first class of infection, fortunately rare, we must confess our inability to in any way combat the activity or the destructiveness of the attack.

In the second class, where the infection is general we resort to the serum treatment, but here we are confronted with the fact, that outside of the diphtheria antitoxic serum, none of the others have proved themselves so efficacious as to reduce the mortality below that which may be obtained under the expectant treatment. With the further development of anti-bacterial sera, this may be disproved, but I believe at present, the results are as I have stated. So that, in other words, the best we can do in this class of in-

fection is to trust to Nature for a cure while we treat unpleasant symptoms as they arise.

Regarding the third class, in which there obtains a subacute or chronic stage of the disease our treatment must be symptomatic and tonic as we have no way of getting at the bacteria in the general circulation.

The fourth class of cases being local, give more scope for treatment. Here several methods are open to us: First, removal of the infecting focus; obviously more cases present themselves where this is impossible or not to be advised, than where it may be accomplished. Second, chemical antiseptics, incisions and drainage. This is probably one of our most exploited methods of dealing with local infections and yet many cases there are, where this is ill advised; further the use of chemical disinfectants in surgical practice is rapidly falling into disuse. Few surgeons there are now, but recognize that saturating an infected area with so-called antiseptic solution, is but inviting an outpouring of lymph which makes a soggy breeding ground for the bacteria left, as only those which come intimately in contact with the disinfecting solution are killed or inhibited and these represent only a very small percentage of those present.

The Bier passive hyperaemic treatment. This, according to the light recently thrown on bacterial infections, seems to be the most rational of the methods so far discussed, as its tendency is, to increase in the infected part, the quantity of the blood, thereby bringing to the infected area anti-bacterial substances to fight the infective process and at the same time, by the passage of the blood through this area, increasing these specific anti-bodies in the general circulation. But this has its almost insurmountable difficulties

under some conditions, as while it may be more or less easy to localize blood in a finger, arm or leg, should the local infection be in the middle ear, appendix or rectum this becomes a more difficult problem.

Wright has shown, quite conclusively, I believe, that the treatment of bacterial infection, by means of the inoculation of specific vaccines, in great part succeeds, wherein all these other methods dismally fail; i. e., in reaching the cause of the infection be it general or local, deep or superficial. It is rational in its behavior, if we accept the latest studies on immunity, and has the distinct advantage over the passive hyperaemic and allied treatments, its nearest rivals, in being applicable to a greater variety of cases; of being more readily controlled and being capable of as much good, with much less danger.

Innoculation with bacterial vaccines is a process of active immunization, in contra distinction to the use of antitoxins which is passive. In antitoxin, there is injected into the individual a substance produced by the cells of the horse, or other animal, which neutralizes the toxin produced by the bacilli in the body of the patient.

In bacterial vaccination on the contrary, the cells of the patient are stimulated to act for themselves and produce the various anti-bacterial substances, which are productive of immunity.

As I have already stated, this immunity while it takes longer to become established, as may readily be conceived, is of more lasting character.

The preparation of vaccines is a matter requiring more or less bacteriological technique. The organism is isolated in pure culture and then grown on agar a sufficient time to obtain a good growth, when it is washed off the slant with salt solution and an emulsion made of it in this medium. A few

drops of this emulsion are put aside for counting purposes and the remainder placed in the incubating chamber, to be heated to 60 degrees Cent. This temperature kills the organism without destroying its protoplasm.

Of the part set aside for counting, a small quantity is taken up in an opsonizing pipette and mixed with an equal quantity of normal blood. This is then smeared on the slide as is done in making a differential count of the blood, stained and by the aid of the microscope, the number of bacteria and red blood cells are counted in a number of fields.

By recognizing that one cubic centimetre of normal blood contains 5,000 million red blood cells, the number of bacteria in one cubic centimetre of the emulsion is readily arrived at.

The emulsion is then diluted to any desired length and put up in sterile phials ready for use. It is best before finally sealing the emulsion to make cultures to insure of its sterility.

The vaccines in general use at the present may be divided into two classes depending upon their origin:

First. Those which have been manufactured, taking as their basis the organism obtained from several different cases of the same infection; as for instance a staphylococcal vaccine produced by growing the staphylococci from half a dozen different cases. These are known as stock vaccines.

Second. Those made from a particular case, using only the organism found in that case, which is afterwards injected into the same individual from whom it was originally obtained. These are known as Autogenous or Personal vaccines.

Of these the stock vaccines are the more generally used since they can usually be more readily obtained; it taking

several days to manufacture a personal vaccine.

It must be remembered, however, that infection by the pyogenic bacteria vary more in intensity than any other bacterial diseases and that this is more particularly so with the streptococci, the several strains of which organism seem to give, at times, very different reactions in regard to opsonic effect.

I had not long since, an interesting case of streptococcal infection which was treated with a stock vaccine while a personal one was being manufactured. The stock vaccine in this instance seemed to have no effect whatever, the temperature remaining at 104° and 105° and the cellulitis increasing. Two doses at intervals of three days of the autogenous vaccine reduced the temperature to normal and quieted the local symptoms. This has been the experience of a number of workers, especially regarding the action of gonococci and streptococci, so that I believe, I am safe in counselling, in these infections, the use of autogenous vaccines.

As in prescribing other remedial agents, the dose of vaccine to be given depends to a great extent upon the age, type of infection, its duration and severity in the individual case.

Of the common vaccines the general dose as recommended by Wright is from 5,000,000 to 50,000,000 bacteria. The exceptions being in the case of staphylococci in which his maximum dose is 1,000,000,000 and streptococci where the maximum he recommends is 25,000,000 bacteria.

Smaller doses are required in children both to start the process and having it started smaller doses may be used throughout the treatment.

The type of infection, its duration and severity are also of importance; long standing chronic infections require larger doses, as a rule, than those which



are more or less subacute; the reason being given for this, is that the more chronic in character the affection the greater is the probability of the normal anti-bacterial substances being completely exhausted and the greater the stimulation necessary to start the machinery of immunization.

In acute infections, bacterial vaccines should not be given. That is to say, in those infections which I spoke of above as class one; vaccines are of no use since they can never be administered in time to be of any value.

In class two, the injury to the cells of the organism produced by the bacteria causing the disease, is sufficient to call forth in the organism, the proper supply of anti-bacterial substances to combat the infection and the injection of bacterial vaccines in these cases will do harm, from the fact as we shall see later, that the immediate effect of their introduction is to lower the vitality or resisting power of the patient. Hence as a general rule, it may be said that bacterial vaccines are contra-indicated in acute infections.

The important features in regard to dosage are:

- 1st. The use of the proper vaccine.
- 2nd. The size of the initial dose.
- 3rd. The proper interval between doses.
- 4th. The proper increase in the dose.

The surest way in which to obtain negative results in vaccine therapy is to jump at conclusions, regarding the causative agent. It is important to remember that a sinus in a tubercular patient, may not always be tubercular and if it is not, any amount of careful treatment with tuberculin will but produce negative results in this case; and even though it be tubercular, if there be staphylococci or streptococci present,

brilliant results will not crown your efforts unless your vaccine is specific for these organisms as well. Hence to insure uniformly good results it is of prime importance to make absolute diagnosis.

Also in this connection, as pointed out in a recent article by Ohlmacher (J. A. M. A., Aug. 15, 1908) not only may the mixed infection be due to pathogenic bacteria but that in many instances particularly in old chronic lesions, the putrefactive bacteria may to a great extent be the underlying cause; and again the same author calls attention to the *B. pyocyaneus* as being one frequently complicating suppurative processes and one most stubborn to vaccine treatment.

It is best to begin with minimum doses of vaccine, (these, as regards the more common vaccines I have given above,) and to proceed to larger doses gradually, taking great care that the dose gives rise to no exaggeration of the patient's symptoms.

Wright says "never advance to a large dose until it has been ascertained that the dose which is being employed is too small to evoke an adequate response."

After a dose of vaccine there is a period of decreased resistance to the infection of a longer or shorter duration depending upon the dose of vaccine administered. This "Negative phase" as it is called by Wright is demonstrated by a fall in the opsonic index of the patient or clinically by a more or less acute exacerbation of his symptoms. This, if the vaccine is properly given, should never be marked and a second dose should never be administered when the patient shows any signs of this phase. The negative phase is transient and is followed by a positive phase in which the index rises

above the previous mark; and here, clinically it is demonstrated by amelioration of all the symptoms.

It is at the beginning of the decline of this period, that the second dose of the vaccine should be given. By administration in this manner, the patient's resistance may be so markedly increased, as to present an index much above that of the normal individual.

Generally, it may be said, that the negative phase will last approximately from twelve to twenty-four hours and the positive one from four to seven days, so that the intervals between doses should vary from four days to a week. It is understood, of course, that individual cases may appear which will need greater or less time between doses than here stated. This, as will be seen later, may be decided either on clinical symptoms or by a determination of the patient's opsonic index.

The faults most frequently leading to failure in this treatment are:

- 1st. Beginning with too large doses.
- 2nd. Increasing the dose too rapidly.
- 3rd. Improper spacing of doses.
- 4th. Increasing the dose after a too marked negative phase.

Regarding the opsonic control in vaccine therapy, it seems to be the opinion of most workers in this country, that the technique of opsonic work has not reached that point of perfection where implicit dependence may be placed upon it.

1st. The opsonic counts of several normal individuals may vary considerably.

2nd. The phagocytic index, based on a count of 50 leucocytes (the number usually counted) may vary in the same serum as much as 30 per cent.

3rd. The higher the index the more prone is the count to error.

4th. There are cases with low in-

dices which clinically show decided improvement and vice versa those whose opsonic index may be shown to be increasing, clinically, show no improvement whatever.

It seems to me that the best that may be said of opsonic control is, that it may substantiate the clinical findings.

While this may be due in part to difficulties in technique, I do not believe it may be attributed totally to this cause. For while the opsonic test may measure a certain part of a patient's immunity to infection, opsonin is only a *part* of the whole and in cases where the opsonic index is low and yet there is decided clinical improvement, may not this be accounted for, in those cases, by a disproportionate increase of the other antibacterial substances over that of opsonin?

Wright and his followers place great dependence in the opsonic control, but I believe the consensus of opinion in this country at least, is, that while it may measure a certain phase of immunity, that it can hardly be said at the present, to give as accurate information as purely clinical control; but that it may be a useful adjunct to the latter.

The important questions to the general practitioner regarding the vaccine therapy are: 1st. Is it the work of the specialist?, and 2nd. To what cases is it applicable?

To the first of these questions I should answer, No. The treatment may be applied by any physician. Opsonic control is not necessary but is probably a useful adjunct both for therapeutic and diagnostic use. In every city in the United States men are using bacterial inoculations under purely clinical control with good results.

It frequently requires bacteriological knowledge to identify the offending organism and bacteriological tech-

nique to prepare the vaccines; but it is only necessary for the therapist to be conversant with the knowledge of how, when and where to inject and by clinical symptoms to recognize not only the different phases of the innoculating process, but their significance.

2ndly. Bacterial inoculations may sometimes be complicated as is the case in mixed or systemic infections; but they are peculiarly applicable, simple in process and successful in result in many of the every day cases to which the practitioner is called upon to treat.

Almost all cases of carbuncles, boils, acne and septic wounds are caused by the staphylococcus and these usually yield as readily to stock as to autogenous vaccines.

Several precautions in their use should be remarked: 1st. The stock vaccines lose their efficacy after about six weeks. 2nd. Wright calls attention to the fact, that antiseptic solutions used in conjunction with bacterial vaccines, destroys to some extent, the efficacy of the latter, in that, the chemical solutions do little good as disinfectants and paralyze the phagocytes. 3rd. The object of the injection is to stimulate the production of anti-bacterial substances in the blood, particularly at the seat of the local infection, hence Wright advocates injecting so that these substances will be carried through the infected area in more or less concentrated solution, as he terms it, he "injects up stream". 4th. Small incisions, to allow the escape of pus, are of advantage and answer equally as well as the large multiple ones, painful to the patient and unsightly on healing.

Under this treatment patients with carbuncle will be found within twenty-four hours to have been greatly relieved of their pain and in three or four days the mass will have sloughed out, leaving a clean granulating surface covered with a scab; this falls off within

three days more leaving hardly any scar to mark its site. What I have particularly noticed in these cases is the freedom from pain produced by the inoculations, as compared with that usually remarked in similar conditions treated otherwise.

One case I wish briefly to mention in connection with staphylococcal infections, interesting I believe, from the fact that the injury produced denudation of the periosteum and slight necroses of the bone. The case was one of a man 40 years old, a seaman by occupation, who received a severe laceration of the great toe, for which he was treated for several months at the Marine Hospital in Chicago, but without much effect. Later for the same condition he was treated by Dr. Charles H. Parkes, to whom I am indebted for the case. When I saw him, there was a small lacerated area superficially, which communicated by a small sinus to the base of the first phalynx. A portion of the bone about the size of a ten-cent piece was roughened and denuded of periosteum. A culture from the bottom of the wound showed a pure culture of the staphylococcus aureus from which I manufactured a vaccine. This I gave to Dr. Parkes, who administered it, beginning with a dose of 300,000 and increased in four doses to 1,200,000 which was continued, at intervals of five or six days, to a complete cure, which has remained permanent. I have not seen any case reported of cure by means of vaccines after denudation or destruction of the periosteum.

Following the method of Wright, I have usually prepared my staphylococcal vaccines, putting them up in 50cc phials containing 600,000 bacteria per cubic centimetre and using as an initial dose, one-half of one cubic centimetre for the adult.

Streptococcal vaccines have been



used with good results in many cases of septic peritonitis; cellulitis; and in conjunction with tuberculin in tuberculouses. More recently, they have been used in scarlet fever, but the results in these cases have not been so encouraging.

The reports from the Massachusetts General Hospital speak most highly of the results obtained here, in empyema from infection by the B. of Friedlander in establishing cures in many cases of chronic sinuses from this cause.

Cystitis, due to infection from the Colon group, yields most satisfactorily, in a large percentage of cases to the Vaccine therapy.

The sinuses so frequent after suppurative abdominal operations have been, according to Floyd and Worthington and other writers, so rapidly and effectively cured, as to recommend this therapeutic agent to surgeons whenever dealing with such cases. The Colon bacillus is most frequently found to be at the bottom of such infections.

In gonorrhea, particularly the chronic forms, in gonorrheal conjunctivitis and gonorrheal arthritis, gonorrheal vaccine has given exceptionally pleasing results. Some writers have recommended its use in the acute forms of the disease, but my experiences in which it was used in the acute stages, does not warrant my looking upon gonorrhea as being any exception to the general rule of leaving acute infections alone.

Regarding gonorrhea I believe auto-genous vaccines should be used on account of the varying intensity of the different strains.

In conclusion, I should like to call attention to the use of gonorrheal vaccine as a diagnostic agent.

Dr. E. E. Irons of Chicago, makes use of this vaccine in large initial doses, so as to provoke the exaggerated symp-

toms of the negative phase; if the case is one of gonorrheal arthritis. In normal individuals or in rheumatic arthritis, this dose of the vaccine does not give rise to any symptoms. I have tried this in several cases with results which would appear to bear out his claim, but as this procedure is rather recent, I believe more proof need be accumulated before it can be finally accepted as an approved method, of differential diagnoses.

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#### A DOG AND A MAN.

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He was a dog,  
But he stayed at home  
And guarded the family night and day.  
He was a dog  
That didn't roam.  
He lay on the porch or chased the stray—  
The tramps, the burglar, the hen away;  
For a dog's true heart for that household beat  
At morning and evening, in cold and heat.  
He was a dog.  
He was a man,  
And didn't stay  
To cherish his wife and his children fair,  
He was a man,  
And every day  
His heart grew callous, its love-beats rare,  
He thought of himself at the close of day,  
And, cigar in his fingers, hurried away  
To the club, the lodge, the store, the show.  
But! he had a right to go, you know.  
He was a man.

—London S. S. Times.

**STRICTLY GERM-PROOF.**

The Antiseptic Baby and the Prophylactic Pup

Were playing in the garden when the Bunny gamboled up;

They looked upon the Creature with a loathing undisguised—

It wasn't Disinfected and it wasn't Sterilized.

They said it was a Microbe and a Hot-bed of Disease.

They steamed it in a vapor of a thousand odd degrees;

They froze it in a freezer that was cold as Banished Hope,

And washed it in permanagnate with carbolated soap.

In sulphated hydrogen they steed its wiggly ears;

They trimmed its frisky whiskers with a pair of hard-boiled shears.

They donned their rubber mittens and they took it by the hand

And 'lected it a member of the Fumigated Band.

There's not a Micrococcus in the garden where they play;

They swim in pure idoform a dozen times a day;

He now imbibes his rations from a Hygienic Cup—

The Bunny and the Baby and the Prophylactic Pup.

—Arthur Guiterman in Canadian Practitioner.

**WHAT IS A MAN?**

"All the constituents of a 150-pound man are contained in 1,200 eggs," said the chemist.

"There is enough gas in a man," he went on, "to fill a gasometer of 3,649 cubic feet. There is enough iron to make four nails. There is enough fat to

make seventy-five candles and a large cake of soap. There is enough phosphorus to make 8,064 boxes of matches.

"There is enough hydrogen in him to fill a balloon and carry him up to the clouds. The remaining constituents of a man would yield, if utilized, six cruets of salt, a bowl of sugar, and ten gallons of water."

No wonder the psalmist said, "I am fearfully and wonderfully made."—K. C. Med. Index Lancet.

**A GOAT IDYL.**

Dr. Johnson, a friend of mine,  
Hung three red shirts upon a line.

Now, what else do you think our doctor did,

But buy a goat for his only kid?

One day this goat, while roaming round,

Spied those red shirts and ate them down.

The doctor was mad, and cursed and swore

That he would have the old goat's gore,  
So he led him to the railroad track,

And tied him there upon his back,

Leaving him in this sorry plight,

Just as a freight train hove in sight.

"Say Au revoir, but not good-bye!"

This goat was far too cute to die.

He strove with all his might and main—

Coughed up the shirt and flagged the train!

The doctor, it would seem, is not in high repute with Paddy. A man in Limerick went to the undertaker to order a coffin for Mike Connell. "Dear me," said the undertaker, "is poor Mike dead?" "No, he's not dead yet," answered the other "but he'll die tonight, for the doctor says he can't live till morning, and he knows what he gave him."—Mass. Med. Jour.

## AN EXTENSIVE APPENDIX.

Will MacMillan, who used to drive our Meat Wagon around but who has been taking a short vacation to regain his health is driving Herman Flenings Meat around while Herman is confined in the Hospital in Town getting his appendicitis cut out which takes two days per week and extends up in Bucks County on Saturdays not saying anything about customers in Fox Chase and Torresdale.—Rustleton (Penna.) News.

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## CONTENTS

Editorial .....	3
Head Injuries, Dr. John R. Espey.....	5
Traumatic Lesions of the Spinal Cord, Dr. John W. Colbert.....	10
Eye, Ear, Nose and Throat, Dr. Clifford S. Losey.....	14
Gastric Ulcer, Dr. Robert Smart.....	16
County Societies .....	19
Routine Examination of the Mouths of School Children, Dr. E. J. Alger..	22

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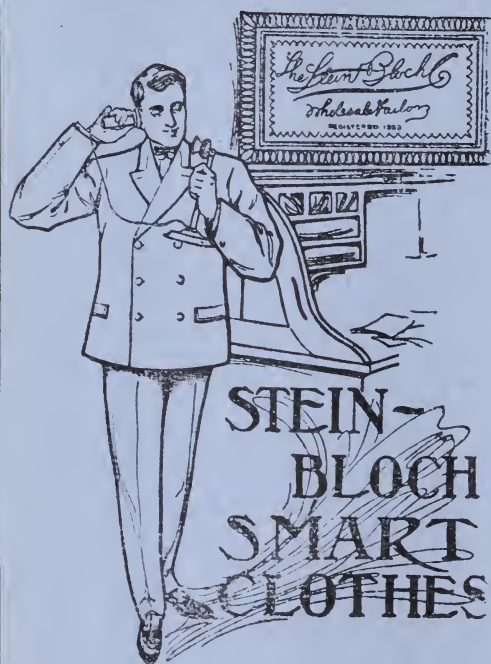
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**EDITORIAL**

The Journal of the New Mexico Medical Society is not a fad. It has come to stay and moreover, it is coming oftener in the future. Beginning with this issue, the Council under whose direction the Journal is published, has decided to issue a number bi-monthly, and the editors will strive to make it even more attractive than heretofore.

We trust that our members will never lose sight of the fact that the Journal belongs to the Society and we must depend upon this joint ownership to enliven sufficient interest to keep it bulging with news, with original articles and searching questions.

One of the principal functions of the

Journal is to provide a medium for the written experiences of our isolated friends, many of whom withhold valuable matter because of a feeling of inability to write. Let no one hesitate on this account. Allow the Journal to serve as a stimulant to literary effort. Far be it from any of us to criticize, and may it be remembered that we are not literary students, but searchers after medical truths.

Our Journal should be welcomed above all others at every office in the Territory. It is the organ which proclaims our advancement, our growth and fellowship and every member of the New Mexico Medical Society should boost and foster it. May it blaze the way in our progress forward and plant the seed from which must come all future fruits.

The Journal has a function also in developing the cause of sanitation by spreading useful and practical information among our physicians, many of whom would otherwise pay little attention to such topics, and also to aid in securing needed legislation.

The policy of the Journal in accepting advertisements will remain unchanged. Thus far the spirit of commercialism has not overcome our desire to keep our advertising pages free from objectionable matter and we have been at liberty to express ourselves editorially without having our remarks characterized as inconsistent with what we advertise.

Let us all get together and make the Journal the pride of the community and an honor to the profession of New Mexico.

An article entitled "I Must Speak", appearing in the January number of the Ladies' Home Journal, from the pen of that wonderful young woman, Miss Helen Keller, at once impresses

one as a simple, truthful story of the cause leading up to ophthalmia neonatorum. We agree with Miss Keller that the cruelest link in the chain of consequences is the mother's innocent agency and that inasmuch as there seems little hope of social reform, laws should be enacted in every State charging criminal negligence to the physician or midwife who fail to use prophylactic measures at every case of childbirth.

Miss Keller's article is upon a worthy subject and appearing in such a medium is bound to receive the consideration which it deserves.

Health Commissioner Wende has appointed five doctors as medical examiners for the public schools in Buffalo. The appointments were all from the eligible list of the Civil Service Commission and took effect August 16. Dr. Callaman will have charge of the parochial schools.

Miss Rose O'Hara has been appointed a school nurse and will look after pupils discharged from school by the medical examiners, and also will see that the physician's directions are carefully observed. Miss O'Hara's name stood at the head of the civil service eligible list.

The Secretary of the State Board of Health in Iowa recently published an article against Medical inspection of schools. In Fort Dodge, Ia., last December, there was an epidemic of scarlet fever. The board of health attempted to inaugurate medical inspection, but was opposed and ordered to stop by the superintendent of schools. The board of health was victorious in the resulting controversy.

Chicago has a hundred medical inspectors who work for the detection of contagious disease. The Commissioner of Health wishes to employ this same

force to conduct regular physical examinations of school children. This is opposed by some of the school trustees, as they doubt the legal right of the board to do this work.

Dr. D. H. Carns, Albuquerque, is the proud possessor of a big new racing automobile. It is the cause of some anxiety, however, for the doctor says when he turns 'er on full blast it gives him a mental squint, and when she runs slow, Dr. Kauffman (his associate) gets too nervous, so he never knows whether to turn 'er off half way, or turn 'er on half way.

Please note that another county society has been formed and joined to the forces of the New Mexico Medical Society and the A. M. A. The physicians of Torrance County, believing in the fellowship and strength of a united body met at Willard, New Mexico, October 29th, and after adopting the Constitution and By-Laws of the mother society, elected the following officers for the ensuing year:

C. J. Amble, Manzano, President.

W. A. Wilson, Willard, First Vice-President.

C. D. Ottosen, Willard, Secretary.

W. E. Sunderland, Estancia, Treasurer.

We extend to the new Torrance County Society hearty congratulations and best wishes for unity, peace and concord.

The Journal wishes one and all a Happy and Prosperous New Year.

#### **Convalescing Victim of an Auto Accident.**

"I woke up and found the hot Welsh rarebit. I recognized it as my wife's cooking, but it was better seasoned than the average."

Nurse: "Merciful saints! we couldn't imagine what had become of that other mustard plaster."—Judge.

## HEAD INJURIES.\*

By Dr. John R. Espey, Chief Surgeon, Victor Fuel Co., Trinidad, Colo.

This paper will not arise to any such encyclopediac proportions as its name indicates and is withal inaptly named, as my intention is merely to call attention to a few of the more important points in fracture of the skull and intra-cranial lesions from violence. These cases are nearly all emergencies and any physician is liable at any time to be confronted with them without special preparation. The patient, frequently unconscious, cannot answer any questions nor give any previous history, and as the nervous system may be functionally inert either with or without organic lesion the question of diagnosis is appalling and cannot in all cases be accurately answered even by the most expert.

First to consider fracture of the skull.

These fractures are the result of great violence particularly falls or being struck by falling objects, gunshot wounds and blows.

The conformation of the skull and the anatomical buttresses or ribs added to the remarkable elasticity of the bones of the skull combine to protect it and its contents from the many serious injuries to which its location exposes it. Consequently, except in diseased conditions of the osseous system, we do not expect moderate violence to cause fracture; and frequently the injury to the contents of the skull is considerable and perhaps deadly when the skull is practically or entirely uninjured.

Obversely, simple fracture of the skull is not of itself a serious injury. The skull is not a vital organ and its simple fracture has undoubtedly, not only in rare instances, but in a large number of cases, escape detection and the recipient has returned to uninter-

rupted work and the enjoyment of good health.

These injuries are only serious as there is concomitant injury to the contents of the skull or as the contents are permitted to suffer damage subsequently by reason of the lack of protection of an intact skull.

Fractures of the skull admit of the same classification as other fractures. Comminution is not so common as in fractures elsewhere and in many of the cases where it occurs the undertaker is called rather than the doctor.

Fissures are more common than in other fractures.

Perhaps the most individuality is shown in the frequent fracture of one table of the skull, the other remaining intact. This possibility is due to the marked stratification of the bone with the two tables separated by the softer diploe. Also one table may be slightly fractural or fissured and the other shattered. In this latter case it is the table more remote from the violence that shows the greater degree of injury—consequently generally the inner table as most injuries are from without. About the only common instance where the inner table is first struck and shows the lesser injury is that from a bullet which has entered the skull cavity at some other point.

The division into simple and compound fracture of the greatest importance in all fractures is even more gravely significant in skull fractures owing to the great risk to life from infection.

Fractures at points remote from the violence even on the opposite side of the skull are said to be due to explosive force following the skull and testing its elasticity and are said to be fractures by *contre coup*. While this probably

\* Read at 27th Annual Session New Mexico Medical Society, Albuquerque, September 3, 1908.



occurs, undoubtedly the term has been greatly overworked and in most of these fractures not due to an opposing or resisting force a fissure can be found post mortem extending from the neighborhood of the applied force. The direct is being accepted as much the more frequent cause of fracture than the indirect force.

Perforated fractures occur and are grave as they are particularly liable to carry infection within the skull and sometimes even beyond the possibility of removal by operation.

Depressed fracture is of course the one upon which rests the greatest possibility of injury to the contents. However, the more recent authorities attach less importance than formerly to the effects of this compression independent of hemorrhage or laceration of the brain. They state that a moderate depression of a not too large section of the skull is quite likely to be borne without bad results either at the time or subsequently.

Diffenbach reports a case of a boy who fell one story, alighting on head and broke right parietal bone with three inches of depression. He was unconscious. Diffenbach trephined and elevated the fragments and the boy recovered and Diffenbach put in his notes that the boy's life was saved by operation. One year later the boy fell and broke left parietal bone in almost similar fashion—no operation was performed and the boy again recovered. Diffenbach put in his notes that he saved the boy's life again and that his former recovery had been in spite of the dangers of active interference. This reveals a view so extreme that I am not certain that it is not partly jocular.

Incised wounds of skull are not common, but occur particularly from edge tools or saws. The outlook in this class of cases depends particularly on chance of sepsis or meningitis as the

injury to the skull itself would not be of large importance.

Roswell Park reports the case of a man who fell upon a circular saw in rapid motion and suffered incision of skull and brain the depth not learned. Hemorrhage was free but ceased spontaneously. The accident occurred in the country and there was considerable disagreement among the several doctors in attendance as to the proper course to pursue. Fortunately this discussion lasted several days by which time it was discovered that the patient was out of danger and recovering without interference.

Another important division of skull fractures is anatomical into fractures of the vault and fractures of the base. The former are generally due to direct violence, the latter often to indirect violence and resisting force although far more frequently than is generally supposed to direct extension of the injury from a fracture of the vault. Thus Scudder makes the statement that more than two-thirds of the cases of fracture of the vault are complicated by fractures of the base and that 85 percent of fractures of the base are accompanied by vault fractures. This statement has somewhat surprised me and I do not find in other authorities at my command so high percentages of fractures at both base and vault.

Fractures at the base are much more fatal than fractures at the vault and some of the older authorities considered them as uniformly fatal. The cause of this greater fatality is their proximity to vital centres and the great risk of sepsis or meningitis by being compound and communicating with the air by means of tracts hard to disinfect and keep sterile as the ear, mouth, nose and naso-pharynx. Probably more than formerly recover owing to better directed efforts to approximate asepsis. I have seen one undoubted case recover

or at least live. It occurred while I was an interne in a Philadelphia hospital and was not my case except as the cases of my chief belonged to me. It was an elderly man with fracture of the middle fossa and he had suppuration from the ear following. He was under treatment at the hospital dispensary for months afterward for the suppuration and severe headaches. He remained mentally very dull and was childish in his tendency to ask irrelevant and unanswerable questions.

The diagnosis of fracture at the base is often obscure and depends on the general symptoms particularly with the discharge of cerebro-spinal fluid and blood from the ears or nose. A free discharge of clear liquid from the ear or nose immediately after injury is almost certainly cerebro-spinal fluid—later it must be distinguished from blood serum from a clot.

Depressed fractures are never seen at the base.

Fractures of vault are diagnosed by inspection, palpation and auscultory percussion—the latter being used to develop cracked pot sound which is pathognomonic. In case of great swelling of scalp or hematoma under scalp the diagnosis may be rather difficult. Then as far as the outer table is concerned it may be cleared up by exploratory incision of the scalp or observation through a laceration in scalp. Blood clot caught in fissure establishes the diagnosis of fracture as it cannot be wiped away, but can when only in the sulci.

The treatment of fracture of the base consists of absolute quiet, cold applications to the head, ergot for hemorrhage, laxatives and—most important of all—antiseptic measures to clean and keep clean any tract that may communicate with the seat of fracture. Helferich says not to irrigate auditory canal as it may drive poison in—other

authorities advise irrigation. The grave danger is sepsis or meningitis from air communication. In case meningitis supervenes it will be indicated by extreme fever, irritability, delirium, and coma followed by death.

I recently had a case of a man who fell three or four feet striking left parietal eminence. No one was with him but he thought he lost consciousness for a few moments, but extricated himself and went home, riding part way in a neighbor's wagon. I was called on his arrival home and found contusion of left parietal scalp and nose bleed. The pupils were normal. I could discover no cerebro-spinal fluid escaping. I was called more particularly to dress a broken thumb which was received at the same fall. This was Wednesday, and he progressed finely without any head symptoms—not even a headache—until Saturday afternoon. In this time the nurse reported some serum to have come from the nose, supposed to have been from blood-clot. I could not discover any discharge at my visits. Saturday afternoon his fever rose rapidly to 105 degrees, agitation, delirium and unconsciousness supervened and passed into coma next day and he died Monday night. Diagnosis—fracture of base in anterior fossa with meningitis from infection coming on at end of third day.

No post-mortem was allowed.

As the treatment of fracture of the vault is the treatment of the intra-cranial lesion exclusively except the general surgical principles of asepsis and antisepsis I think best to mention those intra-cranial injuries briefly before taking up that treatment.

As I have mentioned before the fracture of the skull per se is of secondary importance, injury to the intra-cranial vessels is serious and lesion of the brain itself is most important.

To simplify matters the classification

of these lesions is divided into concussion, contusion and laceration the latter often being accompanied by hemorrhage which produces compression of the brain.

Compression may also be caused by a depressed fracture although this is regarded as far less serious.

These terms describe conditions which probably only differ in degree and are self-explanatory. Concussion may be vibration of the brain or violent displacement of ventricular fluid. It is probable, however, that there is some contusion of the capillary circulation. It is accompanied by unconsciousness, which may be transient, shock, probably nausea and headache. While it is generally the lightest form of injury death has resulted from it and a careful post-mortem has failed to discover any lesion of skull or brain.

Contusion is the next degree in which the symptoms are a little more serious and there is some evidence of capillary hemorrhage and bruising. Concussion may exist without contusion, but contusion induces concussion. The temperature is normal in concussion, but slightly elevated in contusion.

Last fall I treated a marked case of concussion. A railroad switchman was assisting in replacing a derailed engine. As the engine came down on the rail the rail broke, a fragment flying into the air and striking the switchman on the head as it fell. He was rendered totally unconscious, although there was marked irritation with occasional unconscious struggling. This condition continued until I reached him, temporarily dressed his scalp wound, called ambulance and had him transported to hospital—well over an hour. While being taken on litter to his room in hospital he suddenly sat up, looked clear and asked where he was. From that moment all symptoms disappeared.

he talked rationally, slept normally and was well except for the scalp wound.

Laceration is sufficiently described by the name and may be accompanied by hemorrhage which latter may result in compression.

Laceration is also attended by slight fever and deeper unconsciousness. Compression has a slight fall of temperature and then a considerable rise, often reaching 102 degrees. Symptoms of compression from hemorrhage do not generally come on at once and may be delayed for days or weeks. The brain must be quite considerably compressed before we get symptoms of compression. Late unconsciousness excludes concussion but early and continuous unconsciousness does not exclude compression from hemorrhage as the primary concussion may last until the compression takes place. The more recent text books while not at all denying the possibility of serious compression from depression of the skull itself seem to think that such is very uncommon and lay stress on the fact that serious or fatal compression is generally from intra-cranial hemorrhage.

Contusions and lacerations of brain substance may produce glycosuria or albuminuria or even a peculiar form of pneumonia such as might result from a division of the pneumogastric nerve. Vertigo, headache, insanity, epilepsy and paralysis are among the remote effects. Unconsciousness is less prognostic than variations in temperature—subnormal followed by very high temperature giving a bad prognosis. Unconsciousness coming on late also gives a bad prognosis. The non-operative treatment consists of mental rest, cold and quiet to which may be added ergot to check hemorrhage. The non-operative treatment consists of mental rest, cold and quiet to which may be added ergot to check hemorrhage. The non-operative treatment seems to be gain-



ing very much in vogue even among surgeons. The advice of a few years ago to operate in all cases practically undoubtedly led to rash and unnecessary operations and the pendulum must find its level. So enthusiastic a surgeon as the late Senn is quite conservative on the subject of trephining and says: "The surgeon who converts a closed fracture of the skull into an open one without adequate cause assumes a great responsibility."

After all of this is said there will remain many cases demanding operation and the probability is that in communities remote from surgical centres our sins have rather been those of omission than commission.

But do not operate without a definite aim and above all do not operate without thoroughly shaving the entire head and using the most pedantic asepsis and antisepsis.

Now, for what shall we operate?

To insure cleanliness, elevate or remove fragments or arrest hemorrhage. This will lead us to operate in subcutaneous fractures with marked depression in adults, fractures attended by focal symptoms, all compound fractures attended by hemorrhage from the middle meningeal artery or the sinuses. I say operate because these operations are not all trephining as it is better and safer to avoid the trephine in depressed fracture. When operating for hemorrhage it is necessary both to remove clot and arrest hemorrhage. Where possible the bleeding artery should be ligated and if this is impossible an osteoplastic operation should be done to secure it. Herrick says do not suture dura when once opened. All other authors to whom I have access say to suture dura. I have sutured dura under quite considerable tension with only good results. Herrick says do not replace button or fragment of bone in wound. All others advise this in situa-

ble cases. Personally, I have known no defect to ultimately remain when fragments were not replaced. In case of doubt I should rather leave the fragments out than to replace them.

Herrick says hernia cerebri is a myt produced by exuberant granulations and easily cured. Roswell Park describes it as a very dangerous actuality and very difficult to cure. Both are excellent authorities. I have no case of hernia cerebri to report, but I remember seeing Morton at the Pennsylvania hospital handle a so-called hernia cerebri with the greatest respect and call the attention of the class to what he regarded as the dangers of depression or caustics. As I was only on the benches at that time and have seen no case since I will not attempt to settle this mooted question.

The able P. S. Connor gives the following wise advice regarding gunshot wounds, "In gunshot missile penetrating brain and not emerging, find it if you can and if you cannot then give it up." I think we will unanimously agree with him.

This leads me to report a striking case I had some years ago and then I will stop.

A. H., a lad of 13 living at Walsenburg, Colo., shot himself through the centre of the forehead with a 22-calibre revolver because his sweetheart failed to appreciate him. He lay unconscious and was expected to die for six days. At the end of that time as he had not carried out expectations his relatives brought him to the hospital to see if something could not be done. The next day—one week after the injury—I trephined in centre of forehead and found slight comminution of bone and some clot from bleeding from the longitudinal sinus pressing on cerebrum. These were removed and a very tentative search for the bullet was begun, but I soon took Connor's advice

and gave it up. This was before the X-Ray was available. The boy recovered consciousness in 24 hours, but showed some slight paralysis which later wore away in the course of a few months. I think his recovery was complete, notwithstanding that he still carries that 22-calibre bullet somewhere in his skull cavity.

#### FRANKFURTERS CAUSE RABIES.

Winchester, Pa., Dec. 13.—The authorities are conducting a vigorous investigation into the death of John Van Horn, eight, and his sister, Mabel, sixteen, whom the doctors state died of hydrophobia as a result of eating frankfurter sausages. Three other members of the Van Horn family are seriously ill. The grocer who sold the sausages disclaims all knowledge of the fact that the meat was tainted.

#### THE TREATMENT OF CARDIAC DROPSY WITH ERGONE.

(By Hugh M. Moore, M. D., Oxford, Ohio.)

The writer here cites two cases in which Ergone produced remarkable results. He concludes as follows:

"These cases, to my mind, show that in diseases of the circulatory system purgatives and diuretics do not act well until the tension of the blood-vessels is increased. Then only will these valuable agents do their work. It appears reasonable to suppose that a flabby bowel cannot move, no matter how much cathartic medicine is used. Ergone seems to restore the tone perfectly and quickly; even mental symptoms clear up and restful sleep comes, which ordinarily is so hard to secure for these patients."—Southern Practitioner, March, 1908.

#### In Cerebral Cases.

A mustard plaster applied to the spine is sometimes considered quite a drawback.

#### TRAUMATIC LESIONS OF THE SPINAL CORD.\*

By Dr. John W. Colbert, Surgeon-in-Charge, Santa Fe Coast Lines Hospital, Albuquerque, N. M.

The object of this paper is to call the attention of the many railroad, mill and mine surgeons of this Territory to the necessity of adopting more thorough methods of diagnosis in the study of the traumatic lesions of the spinal cord so frequently encountered in their work—and so frequently resulting in serious and annoying medico-legal complications.

No injury which the surgeon meets affords more perplexing and embarrassing situations than these, and it is certainly the duty of every surgeon to protect himself, as well as any corporation he may represent, and the best interests of his patient by a thorough understanding of these conditions—by being able to distinguish, if possible, between the purely psychical, secondarily psychical, and the truly pathological condition. The subject, however, far transcends the limit of time allotted this paper and all I can do is to confine myself to the consideration of the most important practical points of the subject.

In going over the recent literature on spinal injuries I was struck with the great number of cases which remained unclassified, and which were for the most part grouped under the term of "Spinal Concussion". This unclassified group consisted of every variety of spinal injury except fracture or dislocation. The question then naturally suggested itself: "What is meant by Spinal Concussion?" A glance at Webster's, The Century, and the Standard dictionary clearly shows that there is nothing in them to support the use of the word "Concussion" as descriptive of a special disorder of the brain or

\* Read at 27th Annual Meeting New Mexico Medical Society, Albuquerque, September 3, 1908.

spine. In every definition "Concussion" is used to describe the method by which the injury or disturbance was created. Another glance at definitions from recent works on surgery shows each author defining it differently, or at least giving a different description of the signs and symptoms which it embraces. It is unfortunate that a truly scientific interpretation of "Spinal Concussion" has not yet been attained. Does it not plainly teach that there is no such disorder as "Spinal Concussion"—but rather that the term has become established by long usage?

We have then made a poor diagnosis when we pronounce a case one of "Spinal Concussion". The term directs us to no pathological condition, though like some other terms in our vocabulary it serves to satisfy the patient, while confusing the mind of the physician. Why should we not be more definite and apply the word "Concussion" to describe the method by which the injury was received, using other more appropriate terms to describe the resulting disorder? I, therefore, desire to present for your consideration this classification of injuries produced by spinal concussion:

- I. Primary Effects.
  - 1—Sprains.
  - 2—Contusion of the Cord.
  - 3—Hemorrhage into, or around the Cord.
- II. Secondary Effects.
  - 1—Shock, or Collapse.
  - 2—Traumatic Hysterics
    - a—Acute
    - b—Chronic.
  - 3—Traumatic Neurasthenia
    - a—Acute
    - b—Chronic.

In every case of spinal injury we must distinguish, if possible, between a sprain, contusion and a minute hemor-

rhage. If we can be positive that we have had no sprain, contusion or hemorrhage then the case must be considered as purely psychical and treated as such.

In examining a given case of cord injury the first essential is an accurate history of the case. This will often give the nature of the injury—it will give a clew as to whether or not the spinal cord is injured, and will also aid in differentiation. Then comes inspection—which as a general rule gives us the probable location of the site of the lesion and assists in determining the real from the purely psychical case.

Every patient with suspected spinal injury should be stripped to the hips and the back carefully inspected and palpated from atlas to cocyx. Stand your patient in an erect position and have him bend forward and backward a number of times while keeping the knees straight and note carefully the flexibility of the different parts of the spine. Any injured portion will be held rigid by the muscles while the other parts are bending. If this rigidity of a part is noticed then your injury is real and not psychical, for this cannot be imitated. If a sprain be present the normal concavity of the dorsolumbar region noticed when the patient bends backward is absent. Again, with your patient standing in an erect position have him bend the body towards the right and then towards the left, keeping the knees straight, and again look for any irregular muscular action and note the range of motion of the spinal column. Also have your patient while in an erect position twist the shoulders to the right and then to the left without moving his feet, and note the range of motion as before. Inspection, however, is somewhat limited in its scope, and to arrive at a differential diagnosis in traumatic lesions of the cord the general symptoms of such injuries must



be considered. These symptoms may be divided into:

- I—Motor.
- II—Sensory.
- III—Reflex.

The motor symptoms are manifested by complete or partial motor paralysis, or by a greater intensity of motor activity. In an injury involving upper motor neurones you will have spastic paralysis of all extremities—usually incomplete, yet equally distributed to all the muscles. In involvement of lower motor neurones the paralysis is due to disease of the cells of the peripheral motor neurones in the anterior horn of the cord—and only certain muscles are affected and they become flabby, relaxed, atrophied, and show loss of deep reflexes.

The sensory symptoms include changes in tactile sense, temperature sense, pain sense, muscle sense, articular and tendinous sense—and their study requires time, patience and method. Pain is a very important consideration in arriving at a diagnosis of spinal cord injuries. Pain is never referred to a point above the lesion—it is generally below when only nerve fibers are involved and at the seat of the lesion when the roots are involved. A sudden burning, tearing pain creeping rapidly up is indicative of hemorrhage—usually in the membranes, but occasionally in the cord. The so-called “girdle pain”, or root-pain is indicative of inflammation, or degenerative changes in the cord itself. It is significant of a transverse lesion and is of localizing value. The pain area is generally limited in width as it occurs just below the healthy region of the cord where the damaged portion begins.

The dissociation of sensation is a valuable symptom as evidence of slight involvement of the cord. Disturbance of the muscle sense—as evidenced by inco-ordination—especially

when accompanied with articular and tendinous senses, is always indicative of transverse lesion of the cord.

In reaching your diagnosis in an injury of the cord, the study of the reflexes is of vast importance, but greatly neglected. The condition of the reflexes is an index to lesions of the cord since the entire reflex tract is limited to the peripheral or lower level neurones. If the reflexes are lost, exaggerated or diminished we may, as a general rule, conclude that the section of the cord under consideration is diseased. In spinal lesions the knee reflex is of greatest clinical value. The knee-jerk is greatly diminished, or absent, immediately following a severe contusion to any portion of the cord. In an injury above the lumbar region, the absence of the knee-jerk in itself is not sufficient evidence upon which to base a diagnosis of total transverse lesion—as with the resorption of blood, and the recovery from shock to the nerve fibers and cells, the knee-jerks—although absent at first—often return or become more exaggerated. If they have not returned, however, within ten days the lesion must be considered extensive and severe. The exaggeration of the knee-jerk shows that the arc itself has not been destroyed, but that the injury is located above the second and third lumbar segments and the exaggeration is due to cutting off the inhibiting cerebral impulses, or that the gray substance of the cord is disturbed by inflammatory or trophic changes. The loss of the knee-jerk is indicative of a lesion in either anterior or posterior fibres, or both.

The Babinski reflex (extension of great toe produced by irritation of sole of foot) should always be examined for in spinal cord cases—especially in differentiating organic disease. It is to be found in lesions of the pyramidal tract, and it may appear in fracture of

the spine when all other reflexes are absent. The superficial reflexes are generally absent or diminished in fracture of the spine and always absent in complete lesion.

Just a few practical points as an aid in localization of spinal injuries by segmental levels—and I am through.

*Cervical Region*—An injury of any consequence here is followed by serious results. Death follows in total transverse lesions because of involvement of the phrenic nerve and the resulting respiratory paralysis. In unilateral lesions, respiration ceases on one side only—the thorax does not move and the diaphragm lies higher than on the normal side. A lesion in the upper part of the cervical results in spastic paralysis of all extremities and the muscles of the head. Vaso-motor symptoms are to be expected in all lesions of cervical region—ranging from a slight flushing of the skin to pronounced perspiring.

In the *Dorsal Region* the most common symptoms are the so-called “girdle pain”; spastic paralysis of the legs; ankle and patellar clonus; anaesthesia up to and including the diseased segment; variable disturbances of reflexes; difficult micturation, and often involuntary evacuation. In partial lesions of the dorsal region we find disturbances of sensation; sensitiveness of spine; disturbances in mobility of spine, and in gait. Total transverse lesions of the dorsal region are generally fatal.

In injuries of the *Lumbar* and *Sacral Regions* we have involvement of the cauda equina only as the cord proper does not extend below the first lumbar vertebra, and the symptoms are, as a rule, uniform and distinctive—and not to be considered in this paper.

It is impossible in the consideration of spinal injuries—especially those due to railroad accidents—to eliminate the psychical element, that element which eventuates in the development of trau-

matic hysteria and neurasthenia. These psychical elements may often outweigh the true pathology. We have in sudden and severe accidents, as railroad, mine and mill disasters, all the elements necessary for hypotism of the patient, and the unnatural sensations in patients subjected to such accidents easily furnish “suggestion”. We, therefore have “auto-suggestion” as a permanent factor in all these cases. Every railroad, mine or mill surgeon can recall many such cases which have recovered immediately after the payment of damages. In these the injury was associated with a small amount of real damage. The “primary effects” were slight, but the “secondary effects” were exaggerated and continued long after the real injury was well—responding, however, in the majority of cases to the “gold cure”.

The importance of recognizing the definite and demonstrable symptoms is evident because frequently the subjective symptoms coming on suddenly completely obscure the real—the objective symptoms. It is certainly the duty of the surgeon to eliminate, by every possible means, these psychical elements from a case of spinal injury and to discover the true extent of the pathological lesion—and I trust that I have succeeded in bringing to your attention a few practical points as an aid to this end.

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#### English Humor.

It is often asserted that Englishmen have no sense of humor. The sign below, which was posted in a London tavern, seems to indicate the contrary. Here is the sign: “Gentlemen who are learning to read will kindly use yesterday's newspaper.”

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The heroic Bodgers (in horse trough, to would-be rescuer)—Neve' mind me—I can s-shwim. Save the women and children. (Continues to strike out manfully for the shore.)

# EYE, EAR, NOSE AND THROAT.—ROUTINE EXAMINATION IN SCHOOL CHILDREN.\*

By Dr. Clifford S. Losey, E. Las Vegas, N. M.

Our duty as physicians is to conserve the functions of the body, as well as to assist nature in disease, and it is along these lines that this paper will dwell.

When children are placed in school, the Board of Education becomes their guardian for the time being, and it is their first duty to see that their part of the work is fitted to the best advantage of the pupils—properly lighted, ventilated and heated rooms—position of the black-boards and desks and kinds of maps, paper and books.

The desks should be of a size to fit the grade, allowing the feet of the child to rest squarely upon the floor and of such a height as to give an upright position and they should also be placed so as the light will come from the left and back.

Black-boards should be of a dead black or better, white, with the use of black crayon. They should never be placed between windows.

The amount of window space should be from 1-5 or 6 of the floor space and should be swung from the top for the purpose of ventilation.

The size of the print in school books should not be smaller than long primer, and the paper should not have a glazed surface. The color of paper used for maps should be well selected, white or yellow being preferable.

The part of the school board's work being done it is now their duty to see that the parent or guardian does theirs.

Many so-called backward children are so from no other cause than that their eyes or ears may be at fault. The child whose vision is bad or suffers from headache, after use of the eyes, or a child who is defective in hearing, must necessarily appear backward.

The idea is to put in operation some form of routine examination of the children at the beginning of each school year. The plan devised by Dr. Frank Allport of Chicago, covers the ground very thoroughly. It is as follows: The examination should be made privately and singly, in a room apart from the general school session.

Place a card of Snellen's Test Types on the wall in a good light; do not allow the face of the card to be covered by glass.

The line marked xx (20) should be seen at twenty feet, therefore place the pupil twenty feet from the card.

Each eye should be examined separately. Hold a card over one eye while the other is being examined. Do not press upon the covered eye, as the pressure might induce an incorrect examination.

Have the pupil begin at the top of the test card and read aloud as far down as he can, first with one eye then with the other.

If the pupil can read xx (20) test type with each eye and does not, upon inquiry, complain of headache or tired and painful eyes, he may be admitted to school; but if he can not read xx (20) test types with both eyes, or complains of headache or tired and painful eyes, he should be sent home with a card of information to the parent or guardian.

This card might read as follows:

E. Las Vegas, Sept. 3, 1908.

Dear Sir:—

Your son, John Smith, has been examined by me this day as to the condition of his eyes.

I believe it to be advisable for him to consult a physician of recognized standing, from whom he must bring a

\* Read at 27th Annual Meeting New Mexico Medical Society, Albuquerque, September 3, 1908.



certificate, stating it to be wise for him to continue his studies.

Without such a certificate, he must be denied admittance.

Respectfully,  
Mary Jones,

Principal of Douglas Ave. School.

By very simple instructions to the teachers they can readily make these superficial examinations.

The question as to who shall bear the expense of these examinations has often been asked. As for the appointment of some special physician it is, as a rule, too expensive for the Board of Education to pay the requisite salary, and then again, if such was the case, politics would soon come into play and the efficiency of the work would be liable to suffer as a consequence. It seems the best plan is to have the parent or guardian sent the card of warning and leave the selection of the physician to them.

Examinations of this type are now being carried out in many of the larger cities and towns, and in some states are compulsory by law.

Statistics gathered from so many different sources and examiners, must necessarily vary considerably; but, it runs somewhere in the neighborhood of 30 per cent of deficiency.

James H. Blodgett, 1890, estimated that over fourteen million children were in attendance in the different schools of the United States. Considering the percentage of pupils possessing defective eyes and ears, you will readily see what an enormous problem the subservance of these faculties is.

As is well known, the higher the education of a people the more myopes we find. In Germany, probably the most highly educated people as a whole, we find about 50 per cent of myopes; while in the uneducated races, such as the Indian, negro, etc., this percentage

runs as low as 2 per cent. These being facts it well becomes us, to institute measures to prevent them as far as possible.

There is one more prime factor in regard to the attention of school children with diseased eyes; and, especially those of an infectious character. It is my opinion that a child suffering with a trachoma, should not be permitted in school until they have been properly treated and the lids in such a condition that infection is not possible.

The ear diseases most frequently noticed by teachers are suppurative. Many children are deaf from a suppurative condition, or they may have become so from adenoid vegetations in the vault of the pharynx, enlarged tonsils, or any obstruction to the free passage of air through it's natural channels. These conditions frequently produce the "mouth breather", a condition if once seen or noticed, is not easily forgotten. Almost inevitably a child with such a physiognomy is more or less deaf and has throat or nose obstruction or both.

About the only method that is feasible for school testing of the hearing is the voice and watch. In using the former, one ear of the pupil should be closed by an assistant, with the finger. The party testing standing at a distance of twenty feet. The voice should be even and distinct and require the pupil to repeat.

In using the watch, one ear should be closed and the watch held about six feet from the open ear and advanced into the field of hearing. The ordinary watch should be heard at three feet.

I would suggest that the following questions be asked in regard to the ear:

1. Does the pupil frequently complain of earache?
2. Does pus flow from either ear?
3. Does a foul odor proceed from either ear?
4. Does the pupil fail to hear a low

and distinct voice at a distance of twenty feet?

5. Does the pupil fail to hear the tick of a watch at a distance of three feet, with each ear?

6. Does the pupil fail to breath freely from either nostril when the other is closed with the finger?

7. Is the child an habitual "mouth breather"?

I believe that if some form of routine examination could be introduced into our schools, the future generations would reap a rich harvest.

#### Mosquitoes.

A little popular knowledge of science is a great thing. The fact that the sole cause of malaria is the bite of a mosquito has now been pretty thoroughly impressed upon us by the doctors. All mosquitoes do not carry malaria. Only the *Anopheles* are so careless, and only the female *Anopheles* at that. There are ways of distinguishing this particular species, but as Judge is not a scientific sheet, details are out of place here. Besides, we don't know. Malaria, the doctors tell us, does not originate in the mosquito, but is merely carried from some human being who has the disease. He, of course, originally got it from a mosquito, which of course, got it from some human being. Just who began this transmission business the doctors don't say. Besides they don't know. But that the mosquitoes have the secret of biting effectively down to a science everybody knows.—Judge.

#### Tried to Prevent It.

Pa Twaddles: "Tommy, I am not at all pleased with the report your mother gives me of your conduct today."

Tommy Twaddles: "I knowed you wouldn't be, and I told her so. But she went right ahead and made the report. Jest like a woman, ain't it?"

#### GASTRIC ULCER.

(From the Notebook of Dr. Robt. Smart, Albuquerque.)

Ulcer of the stomach may be divided into two classes: indurated and non-indurated.

Indurated ulcer may be seen and felt at operation on account of the cicatricial tissue which forms it. It feels like a scar on the outside of the stomach.

The non-indurated ulcer differs from the first class in that from the outside of the stomach its presence cannot be felt or seen. Even when the stomach is opened it is frequently impossible to find any thickening of the mucosa which will give clue to the presence of the ulcer.

Mayo says "that nearly all the failures of surgery are to be found in this group of so-called clinical or medical ulcers; because, (1) the ulcer is not located and many times its existence is problematical; (2) the condition is often confused with pyloric spasm, atonic dilatation, gastropotosis and the gastric neuroses, or other morbid non-surgical conditions; (3) the ulcer does not give rise to mechanical interference with the progress of the food which would introduce operative indication".

The chronic indurated ulcer gives at first no mechanical symptoms. The pain after eating being due to the excessively acid gastric secretions bathing the ulcerated spots; later due to the formation of cicatricial tissue in the process of repair there may be found obstruction to the passage of food. This leads to a train of symptoms clearly demonstrating retention of food. "Evidence of blood is not deemed essential to the diagnosis in this case" (Mayo).

Chronic non-indurated ulcer is very indefinite in its symptomatology. The chief symptoms are pain, distress after eating, eructations of gas, and spasm of the pylorus. The pathological con-

dition does not lead to the formation of cicatricial tissue, hence there is not the obstruction to food seen in the indurated type of ulcer. The train of symptoms in no way differs in these cases from many non-surgical conditions of the stomach and according to W. J. Mayo "*the actual demonstration of blood is necessary to even give the evidence sufficient standing in court*".

In discussing pyloric spasm, as a symptom of gastric ulcer, at his clinic Mayo has said that it is not always seen in indurated ulcer and while often present in the non-indurated class not much dependence may be placed upon it as a sign of ulcer as it is frequently present in other morbid conditions of the gastro-intestinal tract.

It is pointed out that the posterior wall of the pharynx, the oesophagus, stomach, duodenum, (as far as the opening of the common duct) liver and pancreas are all derivatives of the fore-gut and that all these organs prepare food for absorption. The duodenum below the common duct, the ileum, caecum and colon as far as the splenic flexure are derived from the mid-gut and absorb the food prepared by the fore-gut.

Pyloric spasm is so frequently a manifestation of a diseased condition of the appendix, gall bladder, etc., and not of stomach ulcer that the Mayos look upon it as an irritation set up in some part of the intestinal canal producing irregular attempts to close the pyloric opening to prevent the entrance of food into the intestine where it is diseased below.

Bobby—Ma's in bed with a cold in the nose, and now you've commenced. Sis.

Elder sister (a rabid Christian Scientist)—Dere is do such dig as a code id ner nose.—The Tatler.

## A NEW DIETETIC AND INJECTION METHOD OF TREATING TYPHOID FEVER

With a Report of One Hundred and Thirty-Eight Consecutive Cases Successfully Treated in the Last Ten Years.

Under the above title Dr. F. J. W. Maguire, of Detroit, contributes an interesting article to the July (1908) issue of the Michigan State Medical Society Journal. He bases his conclusions upon experience gained in the United States Marine Hospital service and in private practice. In part he says:

"I noticed when treating children with summer diarrhoea that shortly after giving them nitrogenous food in the form of milk or beef tea their temperature would always rise. I found that by giving these children a carbohydrate diet in the form of barley or rice water I rarely had a rise in temperature. With this observation in mind and remembering the results found in my autopsies following typhoid, I came to the conclusion that milk as a diet in typhoid fever should be eliminated. To further strengthen this theory I determined to carefully watch the results following the use of carbohydrate diet in the form of rice or barley water, etc. In eighteen cases I found the temperature rise following the milk diet, while there was no perceptible increase in temperature after taking rice or barley water.

"I need scarcely add that as a food in typhoid fever I have never since used milk. It is my practice, when I first see a typhoid fever case, to give plenty of sterile water by mouth for five to ten days or until the patient seems to require nourishment, then I use the peptonoids well diluted with sterile water, and the various flavored ices and gelatines. I condemn cow's milk, as it is



a culture medium and the cause of a great deal of local irritation."

With reference to treatment, the Doctor says:

"Having eliminated the milk diet with its terrible irritating effects in the already inflamed Peyer's patches, half the battle is won. This brings us to a consideration of the therapeutic aspect of this subject. In taking up the use of carbolic acid as the therapeutic agent in typhoid fever, I at first thought that I had discovered means whereby I could abort the disease. I commenced by giving half-dram doses of carbolic acid in a pint of sterile water as an enema. This I found very severe. The temperature would drop from 104 to sub-normal and the patient showed signs of carbolic acid poisoning. The temperature would run from normal to 100 for a few hours, then resume its course. The kidneys were carefully watched in all these cases, as they are the filters by which the toxins are eliminated. In my next series of experiments I began with one drop of carbolic acid in a pint of sterile water given as an enema; if the temperature was not reduced I gave another enema in three hours with two drops, and so on increasing until I gave as high as ten drops or the tolerance of my patient allowed. My next series of experiments was with the drop method of injection. I mixed three to five drops of carbolic acid in a pint of sterile water, placed the solution in a fountain syringe alongside the bed and about a foot above the patient, and allowed about one hour for the solution to pass into the rectum. This was regulated by a gauge with a water-glass attachment which shows how fast the water drops. Through the reverse mucous currents this solution is carried throughout the intestinal tract and through this large area of absorption is carried to every tissue in the body."

In conclusion the author says:

"I do not limit the use of carbolic acid injection to typhoid fever. I have met with phenomenal success with this mode of treatment in reducing temperature in pneumonia and gastritis and have carried cases of acute appendicitis to a sub-acute or chronic form, thereby lessening the danger from infection at the time of operation. In these 138 cases reported here today the ages ranged from three to seventy-eight years. I gave no cold baths, but applied ice bags over abdomen, and one bath a day for cleanliness. Occasionally I gave a little strychnine, quinine and salol as indicated. Since adopting this dietetic and carbolic injection method of treating typhoid fever, I have treated 138 consecutive cases. This covers a period of about ten years. All these cases responded readily to treatment, notwithstanding the fact that many were advanced before treatment was begun. Four cases had had most profuse hemorrhages, all of which subsided when the milk diet was removed. I believe by these experiments I have made some very valuable therapeutic and dietetic discoveries, and have sufficient confidence in my treatment that I am compiling a work on the subject."

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#### The Chaplain's Job.

Mr. Stubbs, a leading Republican of Kansas, took his little son to Washington recently, and visited the senate gallery with him. The Rev. Edward Everett Hale especially interested the boy. Mr. Stubbs explained that Mr. Hale was the chaplain of the senate.

"Oh, he prays for the senate, doesn't he?" asked the lad.

"No," replied Stubbs, "he gets up and takes a look at the senate and then prays for the country."

**EDDY COUNTY.**

The Eddy County Medical Society met at Lakewood, on the 15th of December and the program for the meeting was as follows:

"Lymphatic Tuberculosis," by Dr. F. F. Doepp; discussion by Drs. Friedman and Sellers.

"Acute Tonsillitis," by Dr. M. M. Inman; discussed by Drs. White and Furray.

"Professional Ethics," by Dr. J. J. Clark; discussed by Drs. Parr and Baker.

"Typhoid Fever," by Dr. M. B. Culpepper; discussed by Drs. Pate and U. P. White.

After the reading of papers, the Society then elected officers for the ensuing year and the retiring president made an address.

The meeting was followed in the evening by a banquet at which Dr. F. F. Doepp acted as toastmaster.

The following toasts were responded to:

"The Doctor's Wife," Dr. C. M. Whicher.

"The Eddy County Medical Society," Dr. J. Dale Graham.

"The Doctor of the Southwest," Dr. Chas. Montgomery.

The meeting was a most successful one and all report an enjoyable time.

**CHAVES COUNTY.**

At a regular meeting of the Chaves County Medical Society held December 10th, the following officers were elected for the ensuing year, viz:

President—Dr. R. L. Bradley.

Vice-President—Dr. E. M. Fisher.

Secretary - Treasurer—Dr. C. M. Yater.

Board of Censors—One year, Dr. C. F. Beeson; two years, Dr. R. L.

Bradley; three years, Dr. W. T. Joyner.

Many new members have been enrolled and the meetings during the year past have been both pleasant and profitable.

Dr. G. W. Harrison, Albuquerque, has been appointed the New Mexico representative for the National Legislative Council of the American Medical Association.

**BERNALILLO COUNTY.**

At the December meeting of the Bernalillo County Medical Society the following officers were elected for the ensuing year:

President—Dr. W. W. Spargo.

First Vice-President—Dr. L. G. Rice.

Second Vice-President—Dr. H. B. Kauffmann.

Secretary—Dr. John Roger Haynes (re-elected).

Treasurer—Dr. Eligio Osuna (re-elected).

Drs. Charles A. Frank and W. G. Hope were elected delegates to the New Mexico Medical Society.

Much credit is due the retiring President, Dr. C. W. Taylor-Goodman, for the harmony and interest which has endured during the past year and for the vast increase in membership.

**GRANT COUNTY.**

Dr. F. P. Whitehill spent the summer touring Japan, China and the Philippine Islands.

Dr. R. B. Leavell, after a visit to his old home in Louisiana, will locate in Abilene, Texas.

Drs. Bullock, Lake and Hammer attended the International Congress on Tuberculosis at Washington and report a most instructive meeting.

## A NEW PREPARATION OF VERATRUM IN ECLAMPSIA.

(By Alfred M. Huston, M. D., Joliet, Ill.)

A number of remedies have been recommended for the treatment of puerperal eclampsia, and of these perhaps the most popular is veratrum viride. However, as quick results are often a consideration of prime importance in this condition, it would be desirable to have a preparation of this drug which would be available for hypodermatic use. It is quite impracticable to inject subcutaneously the ordinary fluid extracts and other galenical preparations of veratrum on account of the large amounts of irritating substances present. All the preparations I have tried for this purpose heretofore have been open to more or less objection; they were lacking in therapeutic activity, or they were alcoholic solutions and the alcohol was irritating, or they were not properly preserved and decomposed quickly, or their use was followed by suppuration and abscess formation, due to the presence of extractive material which is not absorbed and acts as a foreign body.

I was, therefore, much interested when a new preparation of veratrum viride (Veratrone) was brought to my attention. It is claimed for this preparation that it is physiologically tested and standardized; that it is preserved with Chloretone, which imparts some local anesthetic action to the solution, and that the irritating elements of the drug have been largely removed, leaving only those physiologically active constituents necessary to render the preparation therapeutically efficient, whether it is administered by the mouth or hypodermatically.

The writer goes on to mention several cases in which he has used it with satisfaction, and concludes as follows: "The effect of Veratrone on both the

frequency and quality of the pulse was marked and rapid. I shall certainly give it further trial in similar cases."—*Iowa Medical Journal*, February, 1908.

## DEATHS.

Dr. Samuel M. Crume, University of Kentucky, Louisville, 1906. Formerly of Willisburg, Ky. A member of Quay County Medical Society, New Mexico Medical Society, and American Medical Association, died suddenly at his home in Tucumcari, December 8th.

## Easily Explained.

A theological student was sent one Sunday to supply a vacant pulpit in a Connecticut valley town. A few days after he received a copy of the weekly paper of that place with the following item marked:

"Rev. ——— of the senior class of Yale Seminary supplied the pulpit at the Congregational church last Sunday, and the church will now be closed three weeks for repairs."

## An Excellent Diagnosis.

A medical student who prided himself on being a humorist was running down the steps of the hospital which he was "walking," when he met a fellow student. "Hello, Brown!" cried the latter, noticing that his friend looked pleased. "You're in a hurry. What's the matter—any good cases?"

"I should think so!" cried Brown. "We've got a woman in the ward upstairs who is so cross-eyed that the tears run down her back!"

"Bless me!" said the friend. "You can't do anything for her, can you?"

"I should think we can—in fact, we have," cried Brown: "We've treated her for bacterial!"—*Philadelphia Inquirer*.



## BOOKS RECEIVED.

Report from Pathological Department, Central Indiana Hospital for the Insane, 1907.

"A Text Book of Surgery," by Dr. Arthur Dean Bevan, Professor of Surgery in Rush Medical College, Chicago. D. Appleton & Company, Publishers, New York.

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---

Too Late.

A member of the faculty of the Columbia Medical College at Washington is particularly fond of taking his students unaware in his "quizzes." To one student, whom it would not be uncharitable to call a dullard, the professor said one day:

"What is the dose of oleum tiglii (croton oil)?"

"A teaspoonful," was the answer."

The instructor made no comment; and the student soon realized that he had made a mistake. After fifteen minutes had elapsed, he said:

"Professor, I should like to change my answer to that question."

"I am afraid it's too late, Mr. Blank, your patient has been dead fourteen minutes."

## IODALBIN IN TERTIARY SYPHILIS.

In a recent letter, Dr. J. W. Hamilton, of Warren, Pa., states that he has been using Iodalbin in the treatment of tertiary syphilis and in goitre for the past year, with excellent results and without iodism in any case. In one instance, syphilitic rupia, distributed over the whole body of the patient, disappeared completely in two months under Iodalbin treatment, whereas the patient had been taking iodide of potash three times a day, for a period of three months, without effect. In another case, a gummatous growth of the spinal cord, due to tertiary syphilis, there was a subsidence of all spastic contractions in walking and a return to a normal gait in consequence of treatment with Iodalbin. The doctor concludes his letter with the statement that he now prescribes Iodalbin exclusively in tertiary syphilis.

---

Could Not Read It.

Among the out-patients at an ophthalmic hospital one was an old man. He was turned over to one of the younger specialists, who began to test in the usual manner.

"Can you read that?" he asked, as he pointed to the card placed on the wall.

"No, sir," replied the old man.

The doctor then put on stronger glasses.

"Well," he inquired, "can you read it now?"

The old man shook his head, saying, "No, not a word."

After repeating this performance several times the doctor was about to turn him over in despair to his more experienced superior, when the old man quietly exclaimed: "You see, doctor, I never learned to read."—N. American Journ. Homceopathy.

**ROUTINE EXAMINATION OF THE  
MOUTHS OF SCHOOL CHILDREN  
FOR ORAL DEFECTS.\***

By Dr. E. J. Alger, Albuquerque, N. M.

Mr. Chairman, Ladies, and Gentlemen:—I hesitated some time before accepting the very kind invitation to read a paper before this Society and only decided to take your time as I knew you would help us so much, if you only realized its importance, in a campaign we are planning for introducing free, systematic examinations of the mouths of school children for the purpose of supplying the "ounce of prevention" that is so necessary for the preservation of the teeth; also for imparting such general knowledge as to diet, cleanliness, habits, etc., as will be of value. We must also arrange for a free clinic where those unable to pay for services may get relief.

Our plans are immature as yet and perhaps I should not at present have taken your time, but I felt, as I said before, the value of your help, and also that this opportunity to present the subject might not come to me again. This plan will eventually give valuable data, but its principal object is the chart to be sent to parents, or guardians, showing defects and giving advice, both for acute conditions and also the much needed general information.

Even the casual observer cannot fail to notice the rapid deterioration of the human teeth and the increasing percentage of irregular teeth and he must realize that it is useless to try to overcome this condition in the adult by repairing or replacing, and that unless prophylactic methods are adopted, and unless the deciduous teeth are given proper care that it is only a matter of time when the race will be practically edentulous. It is not necessary to tell you of the systematic conditions connected with a clean mouth, strong teeth and perfect mastication, nor of their in-

fluence on the development and health of their possessor.

I recently read a statement of your much-quoted Dr. Osler, in which he said that as much physical degeneracy was due to poor teeth as was due to the use of alcohol. If an examination of the school children of this city was made I am sure that not over 5 per cent would be found to have perfect teeth and not over 10 per cent who give the teeth any attention whatever, except to get relief from pain, and that in the great majority the only result of mastication was to lubricate the food sufficiently with saliva to permit easy swallowing.

A dentist often hears of somebody's father or grandfather who died at the age of ninety—or thereabouts—and who had "never lost a tooth", but he doesn't *see* any such cases. In fifteen years' practice I cannot remember a patient of thirty years of age with an absolutely perfect set of teeth. I doubt if there are a dozen adults in Albuquerque with perfect teeth, but I know of plenty of children of from two to five years of age who have not a sound tooth and whose mouths are rotten with decayed teeth structure and debris.

Not only are these conditions of the deciduous teeth decidedly bad systematically, both from impaired digestion and danger of infection, but they have a most decided bearing on the health of the erupting permanent teeth, and, the point I most wish to impress, on their regularity of position and proper occlusion.

Teeth that are irregular and do not properly occlude certainly do not have a pleasing appearance, they are more or less defective for mastication and thereby influence digestion. They often interfere with speech; they are more difficult to cleanse; they are more liable

\* Read at 27th Annual Meeting New Mexico Medical Society, Albuquerque, September 3, 1908.

to decay; and they are more liable to pyorrhoea alveolaris.

The first permanent molar—a tooth which erupts at six years of age posterior to the deciduous teeth—is, you might say, the “corner stone” of the permanent teeth, and upon its proper position depends to a great extent their subsequent regularity. This tooth has a great tendency to move forward in the arch and will do so, and thus take space that will eventually be needed by other teeth, unless the deciduous teeth are kept healthy and in place until the permanent ones show that they are about to erupt. This tooth is also very liable to decay and if extracted, no matter at which age, its loss is almost sure to cause poor occlusion, if not unsightly irregularity.

Dr. Angle, our authority in such matters, considers mouth breathing to be the most prolific cause of irregular teeth. In this condition the tongue, especially in swallowing, presses the superior anterior teeth forward and the muscles of the cheeks by their pressure, narrow the arch in the region of the bicuspid and first molars, producing what is called the V shaped arch. Also there may be an undeveloped condition or atrophy of the nasal and maxillary bones that will cause lack of space for the erupting teeth.

Marvelous results are obtained by the Orthodontist in the correction of irregularities, but no permanent one can be had in case of a mouth breather unless the nasal obstruction be first removed; nor can a rhinologist expect permanent results in chronic cases of this kind unless an Orthodontist, after the nasal obstruction has been removed, expands the dental arch and retracts the anterior teeth, so that the lips may properly close.

In conclusion, let me again ask you to think more highly of the deciduous teeth and advise their care, to avoid

their extraction, especially the second molar, until their successors are ready to erupt; never, except in great emergency, extract the sixth year molar; to consider a tooth out of position in as much need of attention as one that is decayed; to consider the Orthodontist a necessity in the cure of mouth breathing; and lastly, to help create interest and co-operation in our plan for the care of the mouths of children.

#### A WORD ABOUT LINIMENTS.

“The surface of the body is a region of objective impressions where influences of every kind are exerted upon nerves and vessels, and through them upon the nervous centers.”

Wherefore, people have for ages sought to subdue pain by applying turpentine, ammonia, croton oil, mustard, cantharides, alcohol, and other things—many of which are harsh and unclearly.

A liniment or embrocation in solid form, of pain-relieving, inflammation-reducing components, so adjusted as to avoid blistering, was conceived to be a big advance on these crudities. Hence Capsolin. It is supplied in collapsible tubes and is convenient to use and economical—very effective in all localized inflammations covered by an unbroken skin.

#### Force of Habit.

Pastor (to druggist convert at the altar): “Brother, have you the hope of eternal life?”

Druggist (absentmindedly): “No, sir, but I have something just as good.”  
—Dr. H. B. Reed.

#### A Financial Success.

“So you were successful in your first case, doctor?”

“Er—yes, yes, the—er—widow paid the bill.”—Tatler.



**HUMAN NATURE**

"I knew a feller once that had  
 The yellor jaunders awful bad, and  
 Each and every one he'd meet, would  
 stop and  
 Give him some receet for curin' of  
 them.  
 But, he'd say, He kinder guessed they'd  
 go away,  
 Without no medicine, and boast  
 That he'd get well without one dost.  
 And so he kept a yellering on, and  
 they  
 Predictin' that he'd die some day  
 Before he knowed it. Tuk his bed,  
 The feller did, and lost his head,  
 And wandered in his mind a spell,  
 And rallied and at last got well.  
 But every one that said he'd die  
 Went back on him eternally."

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## CONTENTS

Editorial .....	3
Diet and Rest in the Treatment of Pulmonary Tuberculosis, Dr. G. S. Sewell .....	4
The Post Operative Treatment of Abdominal Section, Dr. James Vance..	9
The Sequelae of Appendiceal and Puerperal Infections, Etc., Dr. W. H. Burr .....	14
The Eosinophil and Opsonic Index, Dr. S. D. Swope.....	21
Medical Societies .....	24
Book Reviews .....	27

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**EDITORIAL**

The City of Albuquerque, being alive to the necessity of the protection for her school children and desirous of keeping abreast of the times has recently inaugurated a system of school inspection which has proved most satisfactory and is enjoying the endorsement of the best people of the city who send children to the public schools. The system of inspection is much the same as is carried on in the eastern cities, special attention being given to the prevention or spreading of contagious diseases. Every child that is ill is carefully examined before being sent home and must have a physician's cer-

tificate of good health before being readmitted.

After the full confidence of the public has been obtained it is expected that the system of inspection will cover a broader field and will include routine examinations for defects of eye, ear, nose and throat, deformities, etc., with the usual recommendations for their correction.

Albuquerque is to be congratulated on this decided advancement and her action should be emulated by other good towns of our Territory.

The Committee on Public Policy and Legislation of the Territorial Society, after call and due notice, met at Santa Fe, January 18th, which was the opening day of the 38th Legislative Assembly. All the members of the committee were present with the exception of the Secretary (ex-officio member) and Dr. H. M. Smith, of E. Las Vegas.

In accordance with the request of the Territorial Society, the committee met with the Territorial Board of Health, which was represented by Dr. James A. Massie of Santa Fe. It was decided at that meeting to introduce a bill in accordance with resolutions adopted at the last meeting of the New Mexico Medical Society to create a separate Board of Health for the Territory. A copy of the bill was sent to the President of each county society and carries with it the following points:

A Separate Board of Health, consisting of the President and Secretary of the New Mexico Medical Society, the Attorney General, and the Superintendent of Public Instruction, together with other physicians of the Territory who are members of our Society; the Governor to appoint a Health Commissioner for the Territory upon recommendation of the Board of Health, who shall act as Secretary of the Board and receive a salary of \$1,200 per annum and neces-

sary traveling expenses. The duties required of the Secretary includes the following: "He shall collect information, concerning vital statistics, knowledge respecting diseases, and all useful information on the subject of hygiene; and through an annual report, and otherwise as the Board may direct, shall disseminate such information among the people. It shall be his duty to act as correspondent in answering all inquiries made by non-resident physicians and invalids, who are at liberty to call upon him for special information as to the sanative influence of this climate."

The bill also provides that reputable physicians be appointed health officers for each county, with a salary to be paid by the Board of County Commissioners, these county health officers to be recommended to the County Commissioners by the Board of Health.

The committee, through its chairman, Dr. G. W. Harrison, is working hard for the passage of this act, and inasmuch as it has the endorsement of every physician in the Territory, we believe it will receive the consideration which it demands.

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#### MEDICAL COLLEGE CLOSES.

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The Keokuk Medical College, together with the Keokuk Dental College and Keokuk College of Pharmacy, closed recently, after a long career, owing to the small attendance, due partially to the action of the State Legislature enacting stringent laws at its last session regarding entrance requirements in medical schools.

The institution will be merged into the Drake University at Des Moines, the latter institution accepting the Keokuk students and allowing them the same credits and standing as they now have in the Keokuk school.

#### DIET AND REST IN THE TREATMENT OF PULMONARY TUBERCULOSIS.\*

---

(By Dr. S. G. Sewell, Albuquerque, Superintendent, Southwestern Presbyterian Sanatorium for Tuberculosis, Albuquerque.)

The three essentials in the treatment of pulmonary tuberculosis are outdoor air and sunshine, rest and proper diet. The value of outdoor air and sunshine is now generally recognized by both the profession and the laity. In regard to the second essential it is the prevailing opinion among the laity that exercise, especially in the open air, is necessary in order to get well of consumption, and it has not been so very many years since the profession were preaching horseback riding, walking and lung gymnastics in the treatment of this disease. On the subject of diet, the ideas of the laity and a respectable number of the profession as well, have not got beyond raw eggs and milk, the more the better.

Patients are sent out here with instructions to live out of doors and rough it, to climb the mountains and take long walks and ride on horseback, when they ought to be in bed. But it is when the fever and other acute symptoms have subsided and the patient is permitted to leave the bed that there is the greatest need of watchfulness, and it is a clinical fact that the great majority of relapses occur at this time, caused by too much exercise or going to work too soon. It is a law of surgery that inflammation and suppuration are conditions that always demand rest. Aside then from the need of conserving the strength and vitality, chronic ulcerative tuberculosis of the lungs would suggest as near an approach as possible to complete rest of the diseased lung, and the avoidance of those forms of exercise that greatly increase lung movements. Not only is existing in-

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\*Read before the New Mexico Medical Society, Albuquerque, September 3, 1908.



flammation thus aggravated but infectious matter may be forced into healthy parts of the lungs. There is another phase of the subject that needs to be mentioned and that is that rest, of body and mind, is our very best tonic. Appetite and digestion improve and the powers of assimilation are greatly increased. The rest-cure in neurasthenia and kindred troubles is now an established fact. Among the earliest symptoms in tuberculosis, frequently occurring in the so-called pre-tubercular stage, are the asthenia and nervous exhaustion, and proper treatment at this time would prevent the development of many a case of this disease.

In selecting a diet, two things are to be considered: First, what foods the patient can take and keep his digestive organs in a healthy condition, and second, what foods are needed to maintain his nutrition and supply the waste occasioned by disease. As he must get well by what he eats, it is important that no mistakes shall be made. There is usually more or less disturbance of digestion due to toxemia or forced feeding, or perhaps antedating the disease itself, and it is often difficult to get the patient to take sufficient nourishment. A stomach examination would perhaps be wise in every case. This can easily be done in sanatorium work. An Ewald test-breakfast, taken an hour after eating, being careful to pass the tube before anything is taken into the stomach, to ascertain if it has emptied itself over night, will usually furnish all the information necessary. Of more importance is the examination of the stool. When necessary, this should be made at frequent intervals, and should never be left to the patient or nurse. The physician who fails to do this will miss much valuable information. Frequently a constipation will be found to exist with its accompanying autointoxication when the bowels are moving with apparent

regularity every day, or with only two or three stools a day, there may be overlooked a diarrhoea, much of the food passing through the bowels undigested.

The presence of indican in the urine always denotes a putrefaction of the proteids in the intestine. A convenient test for indican consists in mixing the urine with an equal quantity of hydrochloric acid in a test tube and adding a few drops of nitric acid. A change in color to brown or black on standing denotes the relative amount of indican. The symptoms of poisoning from this condition are a slow, hard pulse, cold hands and feet, apparently sub-normal temperature and nervous depression. In tuberculosis there may be a weak, rapid pulse, a general chilliness of the surface of the body, especially of mornings, and while the thermometer may register sub-normal in the axilla or under the tongue, the rectal temperature will show a rise above normal. Whether or not a simple constipation may cause indicanuria, constipation practically always accompanies and greatly aggravates this condition.

We are taught that a normal diet for a healthy adult of average weight should contain 100 grams of proteids, 50 grams of fat and 450 grams of carbohydrates, representing 2,720 heat calories, and that from 35 to 45 calories per kilo of body weight are required, depending upon the amount of exercise. Also that one kind of food can be replaced by one of the others within certain limits so long as the balance in caloric value is maintained, the value of the fats being a trifle more than twice that of the proteids or carbohydrates. Of course to these must be added a sufficient quantity of water and other mineral constituents of the body, and a certain amount of fruits and vegetables, containing cellulose, woody fiber and other waste material to fur-

nish bulk and consistency to the contents of the bowel. In health the appetite is supposed to be a safe guide to the diet, and experience has taught us what is best for us to eat under ordinary circumstances, so that any rules of diet must of necessity be very elastic.

The most noticeable tissue-waste and that which always gives the patient and his friends the most concern, is a loss of the fats. Of more gravity is the impairment of muscle and nerve. As already mentioned this latter is often one of the earliest symptoms in tuberculosis. A simple loss of weight, even though it be considerable, may have no especial significance, and an excessive gain is often pathological. But loss of strength and nervous exhaustion are grave factors in prognosis. It is always desirable to increase the nutrition when the weight is below normal, but it is highly necessary to build up the vitality in order to throw off disease. It is usually a mistake to try by forced feeding with milk and eggs and other foods rich in fats to increase the weight above normal.

For our purpose we may divide foods into two general classes: those that are used or stored up as fuel to supply heat and waste, and those that serve as tissue-builders. The former include the fats and carbohydrates and the latter the proteids and compounds of iron, phosphorus and lime. The proteids may be used as fuel-foods when there is a deficiency of this class, but the starches or fats cannot take the place of the proteids as tissue-builders.

It has been stated that a normal diet should contain 50 grams of fats and 450 grams of carbohydrates, the former having a caloric value of 9.3 and the latter 4.1 per gram. The fats, therefore, contain a high food-value in small bulk, and are useful when the appetite is small and the patient unable to take

much food. The carbohydrates are as a rule easily and perfectly digested and not apt to cause digestive disturbances, and under ordinary circumstances very appropriately form the bulk of the fuel-foods. In the ordinary diet the supply of iron and the phosphates is always probably more than sufficient to meet the demands of the body. Iron is especially abundant in red meat, and in chlorophyll or the green coloring matter of plants, and wheat is rich in phosphates. Milk is deficient in both iron and the phosphates, and for this reason an exclusive milk diet should not be followed for any considerable length of time. The value of the phosphates or of food containing them in abundance in neurasthenic condition is a question that as yet has not been definitely determined. But wheat bread is one of the very best and most easily-digested foods. Made from standard patent flour it contains about 9 per cent of proteids, 1.5 per cent of fat and 55 per cent of carbohydrates. As regards its digestibility, experiments show that about 89 per cent of the proteid and 98 per cent of the carbohydrates are digested by a young, healthy person. Thus it would appear that the proportion of available proteids is a little more than one-half of what is required and the fats are practically wanting. As bread is usually eaten with butter or milk or meat or eggs the deficiency in the fats and proteids is supplied in this manner. Graham and whole wheat bread contain a little more protein than white bread and are also somewhat less digestible, so that the difference in proteid value is more than overbalanced by the difference in digestibility. Breads made from other grains as corn, rye and barley are also below the standard of digestibility of white bread. Without doubt bread constitutes our most valuable article of food, and perhaps, everything considered, most nearly approximates a per-

fect food. When practicable it should form the basis of every diet.

A properly-balanced mixed diet of the foods that come on the table is best when it can be taken. It should consist of bread and butter, meat, vegetables, fruit milk and eggs. Ten ounces of bread daily will contain about 150 grams of carbohydrates, and the vegetables should furnish about 200 grams more. The fruit and sugar, and the milk used in cooking ought to supply the remaining 100 grams. The bread will also contain about 25 grams of proteids, and half a pound of meat about 40 grams more, and the vegetables, fruit and milk used in cooking will furnish the needed 35 grams. The half pound of meat will contain at least 25 grams of fat, and half an ounce of butter 15 grams, and the milk, butter and other fats used in cooking will more than supply the remaining 10 grams.

There is a prevailing opinion that most people eat too much. The fact is that the great majority of ailing persons, those whose health is not up to normal, do not eat enough. This is eminently true in tuberculosis. The foundation for the disease is impaired nutrition. There are very few tubercular patients who take the amounts indicated in the general diet given above.

As the fats and proteids always suffer these should be considerably increased. A quart of milk contains about 35 grams of fats and a similar amount of proteids, and three eggs about 15 grams each of these foods, so that a quart of milk and three eggs daily added to a normal diet would double the fats and increase the proteids one-half. A quart of milk also contains about 50 grams of carbohydrates, so 50 grams each of proteids and carbohydrates with a caloric value of 4.1 per gram, and 50 grams of fats with a value of 9.3 would represent 875 calories or

about one-third of the required daily amount, and three quarts of milk and nine eggs daily would be needed in an exclusive diet of milk and eggs. This would increase the required proteids one-half, treble the fats and reduce the carbohydrates to one-third. To say the least, this is a very uneven diet and should not be continued longer than is absolutely necessary.

A substantial increase in the red meats should be made as these are valuable in building up the nutrition of blood and muscle. Where the acidity of the stomach is not below normal the meats are usually well-borne and relished. In cases of subacidity, or where there is some degree of motor insufficiency the coarse-fibered meats especially should be finely chopped or ground. But when the gastric digestion is impaired it is occasionally difficult to get the patient to take the necessary amount of meat, and when taken it causes more or less distress. This may be due to an excess of the fats. When taken in large quantities they prevent the stomach-juice from thoroughly permeating the food. As it is always most difficult to maintain the necessary amount of proteid in the diet great care should be exercised in this regard, and in all cases of intestinal putrefaction the fats should be looked to as a possible cause.

Where there is fever the patient should be put to bed and kept perfectly quiet. Three light meals a day should be given, consisting of toast or zwi-back or some other easily-digested, starchy food, a little ground meat or tender steak, perhaps a baked apple, an orange or a custard. A moderate quantity of milk and raw eggs should be added, and these may be taken with meals or divided and a part taken midway between meals. Care should be exercised not to overfeed while there is fever. As the condition improves,



meat, vegetables and other articles may be added until a full diet is reached.

Cathartics and laxatives are to be avoided as much as possible, and where there is constipation it can usually be overcome by a modification of the diet. Graham or whole wheat bread, or that made from corn, rye or barley should take the place of white bread, and a liberal amount of fruits and the coarser vegetables, and sugar syrup and honey should be freely partaken of. Regularity at stool should be insisted upon, and when these measures fail, from four to eight ounces of olive oil thrown into the bowel at bed time and allowed to remain over night will usually bring about the desired result. In case of diarrhoea the opposite course must be followed. If not tubercular it can usually be controlled by cutting out all of the rougher foods, fruit and sugar, the last of which may be replaced by saccharin, if desired.

After all, it is a question of educating the patient how to live in order that he may live. It is easy to tell him to rest, and to live out of doors as much as possible, and it does not require very much intelligence to carry out these directions, but to instruct him properly in regard to what he should eat will require much telling and many repetitions.

It may be that the majority of those who contract this disease might be able to get well at home or in their home climate, but there are very few that can keep well without a change of climate or occupation or both. Out here there are many who get well, and many die, but there are others who live on for years or decades perhaps, a life of semi-invalidism, always fighting the disease which may abate, but never lets go, and to which they must finally succumb in the end. It is perhaps to these neglected ones that our strongest duty

points. They are easy prey to every quack in the land, and the victims of their misguided friends, and like the drowning man, reaching out after every straw.

Three things are needed: First, to have our friends in the East who first see these cases make an early diagnosis; second, to recognize the three principles of treatment laid down in the beginning of this paper, and to realize that no case of consumption can be considered cured under at least two years, and third, that we take more pains to educate our patients how to live in order that they may live above this disease.

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#### DRAINING MOSQUITO POOLS.

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The Board of Health of New York has undertaken the work of compelling the owners of property in the Flushing meadows to drain off the stagnant water pools in which thousands of mosquitoes breed. There are a large number of such pools all over Long Island, and a strong wind sweeping over them often drives the mosquitoes to Manhattan and the Bronx. The Board of Health announces that there is no larger number of cases of malaria now than in any other year.—Medical Record.

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In Urinary Retention in children and adults apply dry heat continuously for a time, to the genitals and over the bladder, and often the desired result is quickly obtained. This is especially true in young infants.—Medical Summary.

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Here is a human biography in a nutshell: "Born, welcomed, caressed, cried, fed, grew, amused, reared, studied, examined, graduated, in love, loved, engaged, married, quarreled, reconciled, suffered, deserted, sick, dead, mourned, buried, and forgotten."

## THE POST OPERATIVE TREATMENT OF ABDOMINAL SECTION.\*

(By Dr. James Vance, El Paso, Texas.)

The after treatment of abdominal section is done chiefly on the operating table, for, if the operation is done right, the great majority of patients need little or no after attention.

The purpose of this paper is to touch upon some points only in those cases that we may term simple, in which the operation, no matter how severe, is followed by an easy, uneventful convalescence, and to discuss more thoroughly some features of the after treatment of those cases that, unavoidably or otherwise, have dangerous complications to arise.

In simple cases, nausea is the only complication worthy of mention, and though in our experience there are no drugs that are of value either to prevent or to relieve nausea, we have found that washing the stomach out thoroughly with normal saline before the patient leaves the operating table is a most excellent prophylactic measure and reduces this trouble—some sequellum to a minimum.

For pain we give morphine and hyoscine, because we have seen no ill effects, and it seems criminal neglect in this day of asepsis to let the patient fight the ceaseless pain and endless hours of the first night without aid, when a quarter of morphia and one one-hundredth of hyoscine give the patient a comfortable and generally a sleepful night, followed by courage and cheerfulness to attack the lesser pain of the next day.

The author published, two years ago, an article on the stay of patients in bed after abdominal section, and we have had no occasion to alter our conclusions reached at that time. In interval appendectomy cases with no complications we do not keep the patient in bed at all, except to sleep off the anaesthetic, after

which he may get up as much as he pleases; and on the second or third day they usually begin walking, without any urging on the part of the surgeon—in fact, we do not urge them at all after first getting them up to overcome their natural timidity. We have had hysterectomy cases up in five days and out of the hospital in ten days, and there is nothing particularly unusual in this, for numerous men are now doing this.

It must be remembered that these rapid recoveries are selected cases; not just any case, but the decided exception, since we most decidedly lean toward conservatism, and do not believe in taking any chances at all. We find, though, that we are getting all our patients out earlier than we did some time ago, the average time not being more than two weeks.

In complicated, dangerous cases, shock is always present to a greater or lesser degree, and is generally due to traumatism necessitated by the nature of the operation, and prolonged anaesthesia. Severe shock is usually the resultant of the above conditions, combined with hemorrhage occurring, unavoidably or otherwise, during operation, or oozing of denuded surfaces after operation, and should not occur. Hypodermoclysis of normal saline, if given in time, will prevent shock from any ordinary amount of hemorrhage. In the presence of a severe abdominal operation, the surgeon should instruct assistants to give normal saline at once and not wait, as is often done, till the patient is in collapse, when, on account of the feeble condition of the circulation, the saline is either not absorbed or else is absorbed so slowly that the patient's life is endangered. When this precaution is observed, shock will rarely be severe, and the patient is put to

\*Read before the New Mexico Medical Society, Albuquerque, September 3, 1908.

bed surrounded by blankets and hot water bottles to the extremities. Care must be taken to see that the nurse puts the hot water bottle on the outside of the blankets and not next to the patient, for it is wonderful how little heat it takes to produce a burn when a patient is in profound shock, on account of the very feeble resistance of the tissues. Heat that ordinarily could be stood with impunity, under such conditions may produce third degree burns.

Any hypodermic medication that may seem needed should now be given, and we seldom find use for any other than strychnia gr. 1/30 and nitroglycerine gr. 1/100 together; but of far more benefit than the hypodermic medication is a pint of strong, black coffee at 120° in the reservoir, thrown into the rectum and repeated if necessary in two hours. There is no agent we have ever tried equal to black coffee thus given to bring about reaction from severe shock. Aside from being an excellent heart and nerve stimulant, the coffee acts beautifully upon the kidneys, in this respect being superior to normal saline.

Secondary hemorrhage is something that fortunately does not often occur, but when it does, there is nothing that so tries a surgeon's nerve and is so productive of wrinkles and gray hairs. It is usually produced by the slipping of a ligature, and occurs within twenty-four hours—most often within ten or twelve hours—after operation. The ligature slips from the retching of nausea or more often from the foolish trick of curetting after ovariectomy instead of before.

Few surgeons of large experience have been so fortunate as to have never lost a patient from secondary hemorrhage due to a slipped ligature. The accident nearly always occurs from a broad ligament stump and usually fol-

lowing a simple oophorectomy. We have seen two cases only.

The first occurred when the essayist was assisting. A simple oophorectomy was done and the pedicle tied off securely with a silk ligature by an accomplished surgeon. The uterus was baggy, so it was decided to cruette after the abdomen was closed. This was done and the patient put to bed in good condition, but the surgeon was called in about four hours to see the patient on account of the pulse going up rapidly. By the time the surgeon reached the hospital the patient was pulseless. The abdomen was re-opened as quickly as possible and found full of blood. The ligature was found only partially slipped, so that hemorrhage was probably slow at first till the ovarian artery was completely liberated by vomiting.

The second case was our own, Mrs. L., aged twenty-eight, and a fine specimen of young womanhood who was operated upon for a small, right, ovarian cyst. The pedicle was tied with No. 3 chromic cat gut, and was the sixteenth consecutive case so operated. The patient was sent to bed in excellent condition. Two hours later we were called hastily to the hospital. Upon arrival there the patient was found pulseless at the wrist, with colorless face and lips, and too weak to speak much above a whisper. The patient was at once carried back to the operating room, where the operating nurse had made a sort of preparation. The patient was too near lifeless to need an anaesthetic, and the only preparation of the operator was to plunge his hands and arms into bichloride and hastily draw on some sterile rubber gloves before picking up a knife and re-opening the abdomen. The blood welled up like a fountain. The abdomen was full of blood, but it was easy to plunge a hand into the abdomen and catch the stump by feel. The blood was then



wiped out and the pedicle tied with *silk*. Intravenous infusion of saline was given and whiskey by rectum. During the next ten hours everything was done that could be thought of, and we lost ten years of youth in those ten hours. The patient recovered.

This was the author's private pay patient, and the remembrance of that pulseless, pale as death patient, and that abdomen full of blood will be remembered by him always. Even now we never seat a ligature without thinking of the possibility of hemorrhage, if not of that particular case.

The diagnosis of hemorrhage where it is rapid is easy, for the steadily ascending pulse, the pallor, clammy, sweat covered extremities and forehead, along with a restless, anxious patient, make such a clear picture that the diagnosis cannot be mistaken. When the hemorrhage is very slow, however, the diagnosis may be very uncertain, and the question of the advisability of reopening a very difficult problem. Under such circumstances, a glass, female catheter pushed down through the lower angle of the wound into the pelvis will tell very readily whether there is sufficient hemorrhage to necessitate reopening.

Hysterical conditions following operation may stimulate hemorrhage, and we recall one neurotic patient for whom we removed some hemorrhoids, did a curettment, then opened the abdomen and removed the appendix and an old pyosalpinx and ovary. The patient went to bed in excellent condition—good pulse and no shock. About three hours later we were called to the hospital hastily and found the patient with a pulse of 140 and respiration 75 to the minute. The patient was quite anaemic before operation, and she looked more so then; but the diagnosis of hysteria was arrived at because the

respiration was out of all proportion to the pulse, and the latter was strong in spite of its rapidity. The extremities were also warm and dry, whereas, if we had had hemorrhage, the pulse would have been very weak, the extremities cold and damp, and respiration of probably 30, for in hemorrhage respiration does not as a rule keep pace with the pulse. An eighth of a grain of morphine hypodermatically was given and the patient was soon all right. The morphine was not given till we felt sure of our diagnosis.

Illeus like hemorrhage is far easier prevented than cured, and in all severe, complicated operations where we are likely to have illeus, it is our custom to give following operative, 1/100 gr. of salicylate of eserine by hypodermic every three hours till the bowels move thoroughly, and then discontinue. We sometimes combine atropine gr. 1/60 with the eserine, as recommended by Murphy, but find the efficacy of this combination doubtful.

In spite of all we can do in the way of prevention, now and then we will have a severe case of aordynamic illeus, which may well be defined as intestinal shock in which the motor nerves are at fault and not the sensory. This motor paresis is due to the absorption of toxins, and the severe vomiting accompanying this condition is due to the fact that the stomach is least affected and soon regains its motor function; but the intestine below, still being in shock, has no wave of peristalsis downward to carry off the stomach contents, therefore the pylorus is closed and a reversal of stomach peristalsis takes place and vomiting ensues. Paresis gradually increases in severity from the stomach downward, and reaches its height at the end of the small intestine—at the ileocecal valve. Return of function is likewise from the stomach

downward, so that the gut immediately above the ileocecal valve is the last to regain peristalsis, and until this occurs, all the gut above, by a reversal of peristalsis, empties its contents into the stomach, which in turn is vomited. This vomiting may last for two or three days and without the presence of a peritonitis.

Vomiting in some cases may be aggravated and kept up by some partial obstruction, as in one case we recall severe ileus following a section in which double pus tubes were removed and vomiting continued for a week, till one day several feet of tape worm were expelled and vomiting ceased, followed by easy convalescence.

Confronted with a severe ileus, we at once discontinue everything by mouth, even water; because nourishment, of course, is out of the question, it producing gas and pain, and the stomach has become so irritable that even water adds to the nausea.

We next wash the stomach, which cleanses not only the stomach but a considerable portion of the small intestine below the stomach, because, during the emptying of the stomach, the intestinal contents below are regurgitated into the stomach and so are washed away. Even in the presence of continual vomiting, it is a surprise to the surgeon to see the quantity of material that comes away each time the stomach is filled and then aspirated. Often for four or five times the stomach washings will be full of stomach and intestinal contents. We have seen washing the stomach alone in such cases relieve distressing nausea entirely. Even in mechanic ileus it always relieves for a time.

Salicylate of eserine is given along with any other hypodermic medication that may be indicated, usually strychnia

and occasionally as stated above, atropine.

High enemas, unless contraindicated are now given to remove the gas from the colon and to start the peristaltic wave downward. This stimulation of peristalsis in the colon tends to excite similar waves in the small intestine above, and as soon as the ileum once expels its contents into the colon, nausea ceases and the victory is won, for there is no return of ileus—provided there is no mouth feeding—after the intestine once regains its dynamic function, unless there is a continued source of infection in the abdomen.

We next put the patient in Fowler's position, so that any septic material that may be in the abdomen will gravitate away from the diaphragm, where absorption is greatest, to the pelvis, where absorption is least. This position also, by reason of gravity, lessens nausea and relieves respiration and cardiac embarrassment.

A continuous flow of saline into the rectum for absorption is now introduced. The proper administration of this saline is so important, and so generally improperly given, that it seems wise to detail the technic. An ordinary fountain syringe is used with the hose attached to an ordinary small, hard, rubber rectal tube with a bulb on the end, just large enough when inserted into the rectum to be self-retaining and resist any little pull on the hose as would follow any ordinary movement or turning on the side of the patient. The reservoir with the saline at 120° is suspended by a cord over a pulley attached to a stand which enables the reservoir to be raised or lowered at will. The rubber tip is next held exactly on a level with the patient's rectum and the reservoir lowered till the saline just flows in a gentle stream, and then the point is introduced just

through the sphincter into the rectum. It will be found that the reservoir is only two or three inches above the rectum where the flow is of the right pressure. About a pint to the hour should flow into the rectum and be absorbed when a drain is in the abdomen, and only about half that amount when there is no drain. If the saline will not flow into the rectum, increase the pressure till it just does. If the fluid escapes by the tube into the bed the pressure is too great and the reservoir is lowered until there is no escape of fluid from the rectum, and yet flows into it just enough to keep pace with absorption. When the pressure is just right it will be found that gas will be expelled through the hose and bubble up through the fluid in the reservoir, and occasionally bowel contents will be expelled into the saline. This, of course, should be emptied and fresh saline added.

The saline in the reservoir is kept warm by hot water bags suspended around it, and by the continual addition of hot saline till the fluid in the reservoir is the desired temperature.

Into this saline is put all the nourishment that the patient requires, and should be two and one-half times the amount given by mouth. The best food we have found for this purpose is one of the concentrated prepared foods, of which we prefer Panopeptone.

This method of giving salines is the most important agent we have in treating severe ileus, for this form of ileus always means a severe toxemia from a local or even a general peritonitis, and the saline raises the blood pressure, sustains the heart, flushes the kidneys, thereby eliminating much toxins from the blood, and stimulates peristalsis in the intestines to a marked degree. Added to the above, the value it pos-

sesses as a rectal feeding and stimulating medium is inestimable.

With the treatment above outlined, there will be very few causes of adynamic ileus which will not be relieved within twenty-four hours, but in mechanic ileus there is an obstruction in the bowel that must be relieved by a secondary operation, and then the same treatment is instituted.

Should peritonitis supervene and be the cause of the ileus, the treatment is the same, with the addition of opening the wound at the most suitable place for the introduction of rubber drainage tubes. If the wound is not located properly for drainage the abdomen is opened by a small incision under cocaine at the proper place, and drainage tubes inserted. Any time there is a localized peritonitis followed by pus formation, the abdomen is to be opened in the same way and drained.

In all pus cases we leave the rubber drainage tubes *in situ* till there is no more pus; then they are removed. After the lapse of seventy-two hours, when the tract of the drainage tubes is securely walled off, we irrigate through the tubes with normal saline often enough to keep the pus out of the wound. Healing is in this way very fast and firm, and is rarely followed by ventral hernia.

In septic cases we employ whiskey and black coffee freely. We give whiskey with benefit by proctolysis even in the presence of severe kidney lesions.

In the last two hundred cases of abdominal section, we have had five deaths, three of these were emergency cases, and two prepared.

Of the three unprepared cases, two were gunshot wounds. One, a negro with a bullet-hole through the liver, was moribund at time of operation. The other, a man of 56 years, shot with a .22 calibre rifle. The bullet en-



tered about one-half inch to the left of the annus, passed through the prostate, bladder, cut seven coils of intestines, and lodged behind the stomach. The bladder and intestine were closed and held, but at the time of operation the bullet could not be traced behind the stomach where an abscess formed (as shown by post mortem) which set up a fatal peritonitis. Death resulted at the end of four days.

It seems incredible that the bullet from so small a cartridge as a .22 "short" could penetrate so far, but the fact is unquestionable, as proved by post mortem. The man ran a shooting gallery and was stooping over when he was shot (accidentally, it is supposed) by a Mexican boy.

The first prepared case was that of a returned adenocarcinoma of the left broad ligament of ovarian origin. The operation was long and difficult, and hemorrhage great. Patient died twenty-four hours after operation.

The second case was in a feeble old man of sixty, with carcinoma of the bladder. The bladder was removed and the ureters implanted into the rectum. The operation was too great for the subject, and death from exhaustion resulted a few hours after operation.

In this series of cases, there have been no cases refused operation if there was the least chance of benefit. Almost all operations done within the abdomen are represented, including two cases of general suppurative peritonitis treated by Murphy's method and both recovering.

For Persistent Intestinal Catarrh, Hare says that ammonium chloride, given in grain doses every five hours, is efficacious, especially if in very persistent cases it be given in alternation with 3-grain doses of potassium iodide. —Medical Summary.

# THE SEQUELAE OF APPENDICEAL AND PUERPERAL INFECTIONS, WITH NOTES ON APPENDICITIS IN CHILDREN.\*

(By W. H. Burr, Gallup, N. M.)

My reason for combining in one paper subjects which are apparently dissimilar is in the fact that this dissimilarity is only apparent.

We find the same materies morbi, the same microbic invasion and infection in both cases. It makes no difference whether the streptococcus, the Colon Bacillus, or any other pus-producing germ gains access to the general or local circulation, whether the focus of infection comes from the child-bearing tract, or from a focus in and around the appendix; the results are the same.

It is to call attention to some of the dangers of secondary infection, particularly in appendiceal diseases, that this paper is submitted.

The practice of surgery, like that of internal medicine, is a good deal like the old grandfather's clock, and will be always until we have found out all there is to know about both departments of medicine. The pendulum swings from one extreme to the other according to the individual point of view. The reason for this is because we cannot always give a reason for the faith that is in us. The good old maxim "Usus est Magister", apparently has very little weight today which is to be deplored. We are not satisfied when we have made a certain decision, the result of our own experience and judgment, but listen to the thousand and one opinions, which are often only opinions. Some of our surgeons have been condemned by the so-called conservative element for advising

\*Read at 27th Annual Session New Mexico Medical Society, Albuquerque, September 3, 1908.

ing the removal of all appendices which give any evidence, no matter how trivial, of infection or inflammation. Recent developments seem to show that they were right, and that a patient who carries around with him a diseased organ so intimately connected, through the lymphatic and arterial system, with every important organ in the body, is slumbering over a volcano which may get into action at any moment and so overwhelm the organism that nothing can save it from immediate dissolution. One wonders how many cases of empyema, septic abscesses of the liver, septic endocarditis, Cholangitis, and infections of the gall bladder and surrounding viscera have been treated without suspicion of immediate connection with a diseased appendix.

The following notes of a case reported by Dr. Roland Hill, *Am. Journal of Surgery*, June, 1908, is instructive and to the point:

"Patient seized suddenly June 25, 1907, with symptoms of acute indigestion. Pulse and temperature normal. Eight hours after onset of attack showed tenderness and rigidity in the appendiceal region. Temperature 101, pulse 100. A diagnosis of appendicitis was made at this time and operation advised, but impossible to secure consent of patient. During the next few days there was a gradual subsidence of acute symptoms, though temperature still remained between 99 and 101, pulse between 99 and 100. The pain in the abdomen continued more or less severe and was of a shooting character.

Ten days after the onset patient was seized suddenly with severe pain in the left side of the thorax, in region of left nipple. Temperature rose to 103, pulse 130. Five days later liver became markedly tender and enlarged, and more or less transient jaundice appeared. Pain and tenderness in region of spleen. July 22nd, patient was seen

in consultation with Dr. Stewart. Was pale and emaciated and looked seriously ill. Pulse 130, temperature 102, respiration 36. The record showed that temperature had fluctuated between 100 and 104, pulse 116, to 136, respiration 28 to 36. Tenderness and muscular rigidity in region of appendix. Liver enlarged and markedly tender, absence of vocal fremitus over lower half of left lung, and percussion showed flatness. Exploration with aspirator showed pus. July 23rd a portion of seventh and eighth rib were excised in auxiliary line and about six ounces of pus evacuated.

Improvement in patient's condition did not follow. July 28th occurred first definite chill, followed a few hours later by a second. Temperature rose to 105 and pulse to 140. Profuse sweating and a fall of temperature to subnormal followed. From this time on irregular chills, high fever and sweating. Temperature ranged from 97 to 106. Emaciation, progressive weakness with great depression, dyspnoea at times. August 5th, chill lasted one hour with pulse 152, temperature 107. Leucocyte count 15,000. As the symptoms pointed so strongly to the liver as the probable seat of continued trouble, the patient was again subjected to operation. An exploratory incision was made along the costal border in an endeavor to locate the pus focus. Recent adhesions were found between the liver and diaphragm, the exposed surface presenting the appearance of acute hepatitis, but no boggyishness could be detected. An exploring needle was inserted in four different directions deeply into the liver, in an endeavor to reach pus, but in this we were not successful. Abdomen closed without drainage. Rigors continued and patient died August 19th.

*Post Mortem.*—General peritoneal cavity contained a moderate quantity

of slightly turbid serous fluid. Recent adhesions between liver and diaphragm. Appendix was retrocaecal and constricted at one point, was deeply injected and showed evidences of exacerbation of chronic inflammation, contained fecal concretions. Veins leading from appendix were injected and appeared as red lines. The liver was much enlarged and in the right lobe, near the upper surface, was an abscess the size of a hen's egg. The veins leading to this area were filled with pus, and many small abscesses were scattered in the adjacent area. The spleen was typical of a septic process. Right lung normal, left lung bound down by pleural adhesions. Cultures were made from the liver abscess, blood of heart, spleen, and pus in left pleural cavity. In the pus from liver and left empyema the staphylococcus alone was found. In the blood of the heart short chains of streptococci were found and the bacteriologist who made the examination suggests that the rapidly growing staphylococcus had obscured the streptococci in the liver and left pleura. A number of microscopical examinations were made by Dr. Walter Baumgarten who made the following report:

At the proximal end of the appendix the cavity is greatly contracted and mucosa much thickened. The submucosa for half the diameter immediately adjacent to the mesentery is densely infiltrated with leucocytes and contains a small area of necrosis near the attached surface, surrounded by a zone of round cells. The remainder of the submucosa is apparently normal. The muscularis and free peritoneal surface are normal in thickness and appear normal in all other respects. The cavity at the distal end is dilated and filled with disintegrated material. The mucosa is flattened to a membrane and composed in many places of a single layer of cuboidal cells, in others it con-

tains a few small glands. The submucosa is thin and not inflated in any portion. The peritoneum appears normal. Sections of the kidney show wide spread cloudy swelling and coagulation. In scattered areas, principally in the pyramids, there is an increase of connective tissue. Sections of the liver show general cloudy swelling. Certain lobules have undergone coagulative necrosis some of which shows deposit of fat in the cells about the interlobular veins. The portal spaces are densely infiltrated with leucocytes and the vein is greatly distended. No bacteria could be recognized in any section."

Concerning the diagnosis of these conditions Munroe, in a report of more than 20 cases says that, "A persistent temperature during or following appendicitis, inconsistent with other lesions and accompanied with lumbar spasm, should suggest a lymphangitis."

Fleeting jaundice, irregular chills, hepatic tenderness and progressive emaciation should suggest a portal pyophlebitis following appendicitis, present or remote. In a case reported by Dr. Kelly there was a complete absence of the symptoms between the primary attack and the invasion of the liver. Three days after the apparent subsidence of the appendiceal inflammation the patient was seized with a severe chill followed by high fever and profuse sweating. A second chill occurred two days later, followed by the same characteristic temperature and profuse perspiration. Hepatic symptoms appeared and Kelly operated and drained a large hepatic abscess. The rigors continued, however, and the patient died on the thirteenth day.

Wier has reported a case in which a subdiaphragmatic and also a rectal abscess followed an appendicitis attack.

In Symond's case there was a subphrenic abscess with perforation of the diaphragm and penetration of the lung



following a gangrenous appendicitis. The patient was a girl of 16 with an attack of appendicitis of insidious development, in which the symptoms became gradually more severe. She was operated on the third day and a gangrenous appendix found. Five days after the operation temperature reached 103 and signs of pneumonia appeared. The liver was enlarged and jaundice was present. On the sixth day after operation the patient coughed up foul pus, became cyanosed and was in a precarious state. She was re-operated on and a portion of the eighth rib was exsected in the auxiliary line, and a large amount of pus was evacuated from a subphrenic abscess. Pneumonia which had been suspected was not present and the patient made a good recovery.

Dr. Hill, in speaking of the pathological changes in hepatic infections, says, "They take the form of completely obliterating thrombi in and about the entrance of the portal vein proper, or one or the other of its branches. This infection of the portal veins from its tributaries is usually a slowly progressive process, and results in the formation of a more or less septic thrombus. This thrombus, if detached, may lead to general infection of the circulation. In one of Shoemakers' cases the post mortem showed inflammatory changes in the connective tissue and veins behind the peritoneum and along a path two or three inches wide from the foot of the mesentery upwards along the spinal column. This area was infiltrated with pus, extended for a short distance between the layers of the gastro-hepatic omentum, and involved the structures at the transverse fissure of the liver. In the right lobe of the liver an abscess was found.

In the second case, the appendix was found to be gangrenous. Behind the peritoneum, and extending obliquely

upward from the root of the appendix toward the front of the spine was an infiltrated area of loose connective tissue and veins which could be picked up within the abdominal cavity like a section of the bowel. This when cut across was found to be inflammatory in character. The distended veins within it had thick walls, with a dirty gray lining, and containing a grayish fluid. The liver was enlarged and studded throughout with abscesses of various size."

I have quoted very extensively from Dr. Hills' paper, as well as his bibliography, for the reason that the subject seemed to me to be a very important and somewhat neglected one, and also because in my own practice as that of probably many general practitioners, there have occurred many puzzling cases in which the patients developed sequelae that, in the absence of careful post mortem and microscopical examinations, could not be explained as belonging to the ordinary classical sequelae of fatal appendicitis.

There is no doubt in my mind that if every fatal case of appendicitis, operated or treated without operation, were subjected to a careful examination by the dissecting scalpel and microscope it would be found that even in cases which were operated and succumbed so far as the operation was concerned it contributed little or nothing to the fatality, and the fatal termination was the result of an infection already beyond the power of surgical skill to alleviate.

The lesson to be learned is that there is no such thing as benign appendicitis. That no matter how mild the infection, or how slight the departure from normal exists in this organ, it is a constant menace to the host, and that fatal, irremediable pathologic conditions may arise during the interval between attacks, or before operation.

Between appendiceal infections and

puerperal, the advantage lies with the former in that the condition is generally amenable to treatment, and surgical procedure, intelligently executed, promises a fair measure of success, while in the latter, except the process be limited to the lower lymphatic system of the child-bearing tract, all resources of the most expert surgery are frequently without avail.

The pathological conditions are practically the same in both. We have a bacterial invasion diffusing itself through the lymphatics and veins, in puerperal infection producing a lymphangitis in and around the child-bearing tract with the formation of septic abscesses within the folds of the broad ligament, septic phlebitis and formation of septic thrombi in the sinuses of the placental site, which frequently become diffused with the formation of abscesses within any or all the internal viscera, as well as the external tissues of the body. There is of course a vast difference between sacrificing an important organ, and one whose function is, to say the least, of doubtful utility, and yet, if it could be known positively at what point of time one could be sacrificing the uterus to save the life of a patient, hysterectomy would be the rational procedure in puerperal sepsis.

At the last meeting of the A. M. A. a paper was read, the title of which was "The Symptomless Fibroid." This title is somewhat misleading as the weight of the paper went to prove that any neoplasm, situated anywhere in the body, cannot at all times be depended upon to be symptomless or innocuous. The same may be said of any diseased organ, and the treatment of such is best emphasized in the idiomatic language of a surgical lecturer of the old school, "Take away the cause, and put the part at rest." Conservatism in surgery has no place where a neoplasm or any diseased organ is concerned. This is

well illustrated in the following cases:

Case 1.—Was diagnosed as one of Puerperal Septicaemia. E. F., 23 years gave birth to female child three years ago. History of eczema as child until 18 years. During last pregnancy suffered with more or less pain in region of left ovary, although no report of this was made to accoucher. Confined April 20th, labor finished in five hours. No blood lost during or after labor, not even a clot with third stage. No lochia. In 36 hours from termination of labor patient seized with chill, followed by temperature of 105. Fever continued with intermissions. On third day signs of peritoneal involvement and patient complained of acute lancinating pains running from one ovary to the other. On the fifth day there was evidence of diffusion of infective thrombi into general circulation. Patient died on the sixth day from inception of symptoms of septic intoxication and bactremia, and before abscesses had time to develop in the course of peripheral circulation.

From the history of this case it is possible that the infection developed not from extrinsic causes, but from a neglected foci, inflammatory and infective, in the region of the left ovary and tube. It is unfortunate that no post mortem was held in this case as it is the belief of all who saw the case that had such examination been made the cause of death would have been found to be a neglected inflammatory foci of the uterine adnaxia.

Case 2.—In the practice of Dr. B., Winslow, A. T., E. F. aet. 34, multipara, normal labor lasting ten hours, delivered of healthy male child. This patient had a history of a fibroid tumor of the intramural type which was injured during child birth. No symptoms were developed until the 12th day, when a severe hemorrhage took place from the sloughing of the tumor. This re-

sisted all treatment short of gauze packing which had to be removed in 12 hours. All the tumor which could be reached in that manner was removed with a curette. Strong disinfectant applications were made to the cavity of the uterus, such as peroxide of hydrogen, alcohol, etc., but without effect in the prevention of acute sepsis, from which the patient succumbed on the tenth day from inception of symptoms. This patient had one of the symptomless(?) fibroids referred to in an earlier part of this paper. The fatal outcome was from intrinsic, not extrinsic, causes. A hysterectomy in this case possibly might have saved the patient's life, better a myomectomy in the early months of pregnancy.

*The Sequelae of Appendiceal Infection in Children.* Most all authorities contend that appendicitis in children has a larger morbidity on account of the fact that the symptoms are so often masked, and on account of this fact, there can be little doubt that many children die from secondary infections without suspicion of the original focus of disease. Dr. Holt states that catarrhal appendicitis in children is often not recognized, and that the milder attacks are often passed over as indigestion. Even in gangrenous appendicitis the symptoms for the first few days may be so mild as to excite little or no apprehension until perforation and general peritonitis occurs.

The following brief outline of a fatal case in my own practice illustrates this point, and emphasizes the danger of a conservative line of treatment of these cases:

F. P. aet. 15 years. Former history: At the age of seven had scarlet fever and smallpox. During attack of scarlet fever had scarletinal nephritis with general edema, and albuminuria which lasted for some time. Was taken sick Wednesday, August 14th. Wednes-

day night had cramps all night and vomited all day Thursday. Was called to see patient Thursday evening, and in my absence from town Dr. W. was called. Patient complained of pain in right iliac region radiating to pit of stomach. Temperature 102. Dr. W. put on ice bag and pronounced the case probably appendicitis. I saw the patient next morning, the 16th. Pain much relieved. No palpable swelling or tumor in appendiceal region, little or no rigidity of abdominal muscles. Gave patient a large high enema which was followed by several profuse movements containing feces and a large amount of greenish, slimy material. Pain and abnormal symptoms much relieved. No localized pain anywhere. No rigidity. No anxiety of countenance and temperature went down to near normal.

Wired Dr. S. to come out next day, the 17th, to assist in operating case, but as he could not well get away, replied asking if operation could be delayed to next day, the 18th. As the symptoms were so much alleviated, replied that operation could very well be deferred. Indeed, from the appearance of the patient, was doubtful that the case was one of appendicitis, and only a case of intestinal obstipation. Drs. S. J. and W. saw the case with me on the 18th. There was slight tenderness all over the abdomen, not localized. All agreed that operation was not necessary at this time, and Dr. S. suspected typhoid, as typhoid was epidemic among children in this neighborhood at time. During next two or three days patient was bright, bowels moved once or twice daily and patient complained of being hungry. Temperature slightly above normal in evening. From 21st to 29th temperature distinctly typhoid 101, 102 in the morning, 103, 103½ in the evening, bowels moving two or three times in the day. Made several examinations of the urine which contained



some albumen, but at no time showed the diazzo reaction. On the 26th, 27th and 28th, urine progressively scanty and high colored. On the morning of the 28th patient began to vomit dark colored mucous and greenish fluid. At 2 p. m. pulse 160, temperature 101. Between 2 p. m. and 4 p. m. temperature went subnormal, 96, patient complained of intense pain all over abdomen, particularly referred to ziphoid appendix. Urine scanty, high colored and loaded with albumen and exudates.

Gave patient high enema at 6 p. m. and pulse came down to 108. On the 28th and 29th saline enemas every six hours, followed by nutritive enemas. On the 30th and 31st patient was again able to take milk and lime water. Drank albumen water and several glasses of plain water. Urine increased. During past three days patient had hot air baths and cups over posterior region of kidneys.

On the morning of the 31st, patient began to vomit again and abdomen became tympanitic. Two enemas of olive oil were given with some relief to patient. September 1st patient was removed to hospital and operated on at 2 p. m. Abdomen opened. During the manipulation a small abscess was ruptured. Appendix buried in a mass of adventitious tissue and not removed. A large rubber hose was put in, with gauze for drainage, also drainage through the flank. Patient improved for several days, tympany somewhat relieved, bowels moved freely. Shortly after operation fecal matter was passed through both drainage tubes, but amount passed this way gradually diminished. This continued until the evening of the seventh day after the operation, when patient began to vomit again, vomit of fecal character, discharges ceased and tympanites slowly

increased until it interfered with her respiration. Patient was placed on the table and upon opening the original incision it was found that a space about an inch square in the large bowel had become gangrenous and dropped out, leaving free agress of bowel contents into the free peritoneum. This opening was stitched to the abdominal wound and patient returned to bed, but did not rally from the second operation, and died the next morning.

This very interesting case emphasizes the uncertainty of classical signs and symptoms in appendicitis in children. It also opens up the very pregnant question as to when to operate, one, it would seem in the settling of which, we should recognize no authority but our own judgment. Of late there has a good deal been said in favor of Ochsner's dictume, that if a patient is not operated on within the first 48 hours from the beginning of symptoms, one should wait for the interval operation. If you follow this teaching, which it is claimed has saved a number of lives, the question comes in: how long should you wait? In the cases just reported 48 hours had already elapsed before a physician was called, the attack being set down to an ordinary case of indigestion, and at no time after I saw the patient, until she was in extremis, did the circumstances of the case seem to indicate the necessity of an immediate operation. Yet it is probable that an early operation, or at any time after the patient was first seen, would have given her a better chance for her life. The case was rendered complex by the fact of an epidemic of typhoid, as also her history of renal trouble.

In the discussion regarding the interval operation before the Section of Surgery this year, the weight of opinion was all with Ochsner's method, but Dr. Morris of New York dissented and

stated "that he had operated on every case of acute appendicitis that he had ever seen if the patient was breathing when he got to him," and he reported one hundred cases of all kinds, operated at the Post Graduate Hospital since January 1st, with one death, the latter being due to ileus from faulty re-adhesion of bowel. Dr. Morris stated to me later in a letter that he had a series of 100 or more cases, including his private practice, without a death, and mentioned one case, appendicitis during pregnancy, in which he had refrained from operating, fearing abortion and secondary infection. This patient was operated on later by another surgeon, when in extremis, and lost her life. It would seem in the cases reported that Dr. Morris' method would have been the safest, and that there was no time after the patient was first seen but that her chances under an immediate operation would have been better than the waiting plan which was followed. I will conclude this paper with one emphatic bit of advice, which I think will carry the authority of all the surgeons in the country. In all desperate cases of appendicitis upon which you conclude to operate, especially those complicated with general peritonitis, "get in, and get out as soon as possible". Put in plenty of drainage, and leave out all irrigation. Wipe out what pus you can get at easily, but do just as little manipulation as possible. Following this plan a certain number of desperate cases will recover.

During the past summer Dr. Murphy operated a case of typhoid perforation, using only a few minutes for the operation, and leaving within the abdominal cavity a quantity of bowel contents which he did not attempt to remove. The patient recovered and was exhibited to visiting members of the A. M. A., as a living example of such teaching.

### THE EOSINOPHIL, AND OPSONIC INDEX.\*

(By Dr. Samuel D. Swope, Deming, N. M.)

Gentlemen: I have no better apology for bringing this subject before this honorable body than to quote the statement of Verworm: "If the pathologist and clinician desire to advance in the knowledge of the manner of the different processes of disease, they must have definite conceptions of the general activities of living cells.

It has now been nearly a century since the first awakening dreams of the clinician and pathologist were turned to the action of the cellular elements of the blood for an explanation of some of the physiological phenomena and pathological effects of certain conditions. It was reserved for the great German pathologist and investigator not much more than a decade past to shed the first real light of the morning of science on what had hitherto been but a dream, on this most important subject. When Metschnikoff gathered together the scattered threads of metabolism, phagocytosis, agglutination and many other wandering suggestions to weave out of these states two terms, that are practically united to form a line to which our future progress in the science and art of medicine is apparently firmly tied, phagocytosis and the Opsonic index.

Eosinophilia, that peculiar phenomena of the blood with its immense cells so easily stained with eosin, evidently has not yet emerged from the benighted state of uncertainty to take its place upon the illuminated stage of science. That it appears in nearly all conditions where pathologic processes have lowered the vitality, impeded the phagocytosis and lowered the opsonic index, is well established. The phenomena has

\*Read before the New Mexico Medical Society, Albuquerque, September 2, 1908.

been studied in trychinosis, asthma, leukemia, psoriasis, tuberculosis, after the ingestion of potassium iodide and nearly all wasting diseases. They appear materially increased in the weakened state of early infancy and I have found them increased in chronic nephritis, empyemia and pyemia.

Though the aesyphil are attracting more and more attention from the researchist their place has not yet been established nor their functions yet understood in the great drama of life.

This we know that their presence indicates a grave pathological condition, the pathognomonic symptomatology of which we must look further for, with the ever present hope that this beautiful chromatic cell in whose existence the scientific world is so much interested, will yet lead us forward over the not too smooth path of diagnostic knowledge.

We are indebted to the great Metschnikoff for the initiatory introduction to the phenomena of opsonins, as well I think for the name (Opsonic, from the Greek, I prepare vituals for; I cater for).

In studying the phagocytic action of the white blood cells there became apparent to this great mind the evidence of the presence of an agent or agents that influenced the phagocytic action of the guardians of the human economy. This phagocytic activity, and the changes incident to the administration of certain agencies, constitute the opsonic index.

Further studies of the phenomena by Dennis and Leclef, in 1895, served to elucidate certain points. Mennes, Leishman, Wright, and Dougless followed by Neufeld, Rimpan and Ross, have contributed materially to the subject, until the present time no laboratory is complete without an opsonic outfit and no obscure diagnosis is jus-

tifiable without a study of the opsonic index of the patient.

By this means the action of various agencies upon the human economy may be determined; when formerly we were compelled to grope in the darkness of empiricism for their physiological effects.

The mystery of the action of normal salt solution is explained, by its stimulation of the phagocytic action as well as its influence on the nerve elements, thus raising the opsonic index, with a corresponding improvement of the condition of the patient. The action of cinchona on malarial infection can thus at last be explained. The action of tuberculin and other antitoxins are thus removed from their shroud of mystery through the light of opsonins.

With these facts before us who can stand before the poorly paid laboratory researcher with uncovered head. In the by-ways and hedges of general practice we must look to him for the lamp of knowledge that must yet lead our wavering steps to the realm of future certainty. If he sometimes leads us temporarily astray, he has inevitably led us back to the straight and narrow path of certain knowledge.

With these physiological phenomena before us, the therapeutic application of the knowledge becomes practically mechanical. The theory of phagictosis that was termed an ingenious fatuous when first suggested by Metschnikoff, with the index opsonins to guard its actions, has within a score of years become our chart and log-book.

This is not the end. The statement of the French physician two hundred years ago, when he wrote, "I feel sorry for posterity since there are no other truths to discover," is no more true to-day than then. The great future holds most wonderful truths for those who shall be enabled to cut the pages of the book of knowledge.



We are now trying every agent known to increase the opsonic index of the afflicted, from normal salt to elephant's blood serum. How wonderful is the mechanisms of human life and how peculiarly the pendulum swings from age to age. Who knows but what we may yet return to the pulverized frogs eyes, that were given as medical agents before the Christian era, and find the opsonic index of exophthalmic goitre, materially improved by the ingestion of this agent.

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**A GIFT TO THE NEW YORK POST-GRADUATE HOSPITAL.**

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Dr. Frederick Cooper Hewitt, of Oswego, New York, has bequeathed the New York Post-Graduate Hospital the sum of \$2,000,000. Dr. A. F. Chase, secretary, says: "The gift will make possible the carrying out of plans which have long been cherished by the board and which will place the Post-Graduate School ahead of all the foreign institutions of its kind."

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**THE SAMUEL D. GROSS PRIZE FIFTEEN HUNDRED DOLLARS.**

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Essays Will Be Received in Competition for the Prize Until January 1, 1910, at the Philadelphia Academy of Surgery.

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The conditions annexed by the testator are that the prize "Shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the competitor who receives the prize, shall publish his essay in book form, and that

he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page, it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 219 S. 13th St., Philadelphia," on or before January 1, 1910.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

WILLIAM J. TAYLOR, M. D.,  
RICHARD H. HARTE, M. D.,  
DEFOREST WILLARD, M. D.,  
Trustees.

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**INFANT MORTALITY IN CHICAGO.**

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Six hundred and sixty-nine babies died during the month of July in Chicago. Probably two-thirds of these deaths could have been avoided, had most of them may be attributed to ignorance and neglect of the parents. The Department of Health is now directing the work of seventy-five physicians in the crowded districts of the city, educating mothers in the proper care of their children.

**LUNA COUNTY MEDICAL SOCIETY.**

The Luna County Medical Society met in regular session January 13th. Owing to the illness of the President, Dr. J. B. Barbee, Dr. S. D. Swope, the Vice-President, presided. The minutes of the last meeting were read and approved. Dr. S. D. Swope reported an interesting case of double pneumonia in a primipara of eight and one-half months gestation, with delivery and successful termination. Dr. P. M. Steed reported a nice case of twin delivery, mother and babies doing well. Dr. J. G. Moir presented a case for examination and a diagnosis of cystic gall duct obstruction was made.

No further business, the meeting adjourned.

The Luna County Medical Society is in excellent condition. Our field is not large, we are few in number, but a most fraternal feeling exists for each other. We can boast of having had no trouble or friction during the existence of the Society. So may it ever be. What other medical society can boast of the same?

J. G. MOIR, Secretary  
Deming.

**GRANT COUNTY MEDICAL SOCIETY.**

Dr. R. E. Wells has opened an office on Bullard Street, Silver City. Dr. Wells comes from Traverse City, Mich., as a health-seeker, but will no doubt make Silver City his future home.

Among the physicians who have lately come here from the East are: Drs. Hardy, of St. Louis; McWilliams, of Pittsburg; Barton, of Philadelphia, and Careldine, of Louisville. Dr. Careldine is staying at Sunnyside Ranch, a new sanatorium for tuberculous patients.

The diphtheria epidemic which has

been prevalent here during the last two months, is entirely under control, there being but two cases now under quarantine.

At the beginning of the year a new sanatorium for tuberculous invalids was opened under the medical supervision of Dr. LeRoy S. Peters and the business management of E. A. Woodhull. The institution was opened to care for the average patient who is unable to afford the high rates of the other institutions in the Southwest and elsewhere. The sanatorium is built on the cottage plan and consists of a main building containing recreation hall, dining room, kitchen and offices, together with over twenty cottages designed especially to meet the needs of those suffering from this disease. The cottages open from all four sides providing a room equal to a sleeping porch, and yet as comfortable as one's own home when closed against storms.

The institution though but two months old, is now caring for twenty patients. A new administrative building is to be erected this summer.

**BERNALILLO COUNTY.**

The meeting of January 5th was held at the residence of Dr. W. G. Hope, nineteen members being present.

Dr. J. W. Elder read a very interesting paper on "Coughs". Dr. R. L. Hust led the discussion, and Dr. H. B. Kauffmann conducted the quiz.

Dr. P. G. Cornish made clinical reports of several cases.

After the meeting refreshments were served by Dr. C. W. Taylor-Goodman and Mrs. Hope.

At meeting January 20th, Dr. P. G. Cornish read an interesting paper on "Fracture of the Hip", which was

thoroughly discussed by all. Dr. E. Osuna conducted the quiz.

The Secretary read report for 1908, which showed that there were 12 regular meetings, one business meeting, and one called meeting. Total attendance, 196. Visitors present during the year, 29. Number of papers, 11. New members, 16.

At this meeting Dr. M. G. Cartwright was elected to membership.

At meeting of February 3rd, there were 16 members present. Dr. C. H. Carns read a paper on the subject of "Surgical Emphyema". A general discussion followed and a quiz was conducted by Dr. L. G. Rice.

One application for membership was received.

There were 19 members present at the meeting of February 17th. A very interesting paper was read by Dr. S. G. Sewell entitled, "Some Consideration on Diet." Discussion was general, followed by a quiz, conducted by Dr. J. W. Reidy.

Dr. Frank de la Vergne was elected to membership, and two applications for membership were received.

JOHN ROGER HAYNES,  
Secretary.

#### COUNTY SOCIETY NOTES.

##### Luna County Medical Society.

At the last regular meeting the following officers were elected to serve for the ensuing year:

President, Dr. J. B. Barbee.  
Vice-President, Dr. S. D. Swope.  
Secretary, Dr. J. G. Moir.  
Treasurer, Dr. P. M. Steed.  
Censors were elected as follows:

Dr. S. D. Swope, for a term of three years.

Dr. P. M. Steed, for a term of two years.

Dr. J. G. Moir, for a term of one year.

The Treasurer's report showed a nice balance after paying all expenses of 1908.

##### Las Vegas Medical Society.

The following officers were elected at a meeting January 13th, to serve for the coming year:

President, Dr. W. R. Tipton.

First Vice-President, Dr. G. H. Goelitz.

Second Vice-President, Dr. F. T. B. Fest.

Secretary, Dr. W. E. Kaser.

Treasurer, Dr. H. J. Mueller.

Censor, Dr. E. B. Shaw.

#### MARRIAGES.

Dr. Howard Crutcher and Miss Ellen Nilsson, both of Roswell, were married at the residence of the bride's parents on Christmas Eve.

#### WHY LINCOLN TOLD STORIES.

The reputation of Mr. Lincoln as a story teller did him some injustice, for not only the stories he told, but many that are apocryphal, have given many people an impression that he told stories to be entertaining. Judge David Davis, Governor Richard Oglesby and other men who were intimately associated with Mr. Lincoln always insisted that he never told a story except to illustrate a point in an argument and make it plainer, and never for the love of



telling the story or being entertaining. Lincoln's whole life was given to serious consideration of serious problems before the people, and he gave his life to the people not only in the final sacrifice, but in all his study and efforts from the time he enlisted in the Black Hawk war.—Leslie's Weekly.

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**PERMANGANATE OF POTASSIUM AND  
SNAKE-BITES.**

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Good results continue to be gained by the use of permanganate of potassium in cases of snake-bite. Reports from 18 districts in Bengal during last year show that in 198 cases where the treatment was resorted to there were only 23 deaths. In a number of instances the persons bitten were not received in hospital until the fatal symptoms had developed, when the permanganate fails, of course, in its effect. The cases which come under treatment are comparatively few, as the people still believe in their snake charmers, but it is hoped that the efficacy of the new remedy will gradually become known to all classes. It is suggested that as the treatment is very simple and efficacious governments might well order that every police station and outpost, every school and every president of a panchayat, should be provided with permanganate lancets, so that cases of snake-bite may receive the earliest treatment. This is a very practical suggestion; the cost of the lancets would be trifling and the number of cases treated annually would probably rise from hundreds to thousands.—British Medical Journal.

**ADMONITION TO GOVERN THE TONGUE,  
UNRULY MEMBER.**

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Do not profane your tongue with slander, for even though that is directed to harm somebody it will return to yourself, and it will be the more painful the more malicious the slander. If your tongue forces you to offend another, make an effort to lock your lips; do not fear even to ruin your body; for slander ruins people, but it ruins not those against whom it is directed, but him from whom it emanates.—Jewish Wisdom.

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Try to cease condemning people and you will experience a sensation similar to that experienced by the drunkard who leaves off drinking, or the smoker who stops using tobacco; an exceedingly pleasant sensation of cleanliness and also at first a desire from time to time to return to the habit.

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Always watch yourself, and before judging others think of your own improvement.

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Turn away from slander and false witness. May your tongue always serve you as a weapon of truth.

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Slander at once harms him who is slandered, but most of all him who slanders.

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Much harm may be caused by imprudent praise and condemnation, but the greater harm is caused by condemnation.

—Ruskin.

## BOOK REVIEWS.

**Arteriosclerosis.** Etiology, Pathology, Diagnosis and Treatment, by Louis M. Warfield, A. B. M. D., Instructor in Medicine, Washington University, Medical Department; Physician to the Protestant Hospital, Adjunct Attending Physician to the Martha Parsons Hospital for Children, St. Louis, Mo. Formerly Medical House Officer at the Johns Hopkins Hospital, Baltimore. Member of St. Louis Medical Society, the Missouri Medical Association and the A. M. A. Eight original illustrations. C. V. Mosby Medical Book & Publishing Co., St. Louis. Price, \$2.00.

This little volume contains all that is best and modern in the consideration of this subject and will be appreciated for its compactness. It is instructive and written in a style that is entertaining and altogether the work is a most helpful contribution to the study of this important subject.

**General Surgery.** A Presentation of the Scientific Principles upon which the Practice of Modern Surgery is Based. By Ehrich Lexer, M. D., Professor of Surgery, University of Königsberg. Edited by Arthur Dean Bevan, M. D., Professor of Surgery, Rush Medical College, Chicago.\* D. Appleton & Co., New York.

This volume has 450 illustrations, and is particularly adapted to the use of the busy practitioner who looks for something concise, up-to-date, thoroughly illustrated, and backed by excellent authority. The chapters on Infection and Immunity are particularly attractive. The subjects of Opsonins together with Wright's Vaccine Therapy are discussed in the appendix, their theories and merits being well expounded.

A valuable book for every practitioner.

**Medical Gynaecology.** By Howard Kelly, A. B. M. D. LL. D. F. R. C. S. (Hon. Edinburgh), with 163 illustrations by Max. Broedel and A. Horn, New York and London. D. Appleton & Company, Publishers. 1908.

To criticise a work by this favorite author would be but to enlarge upon its merits. The excellence of the illustrations, the modernism of the text and reliability of author-

ship should at once create a demand for the work such as a volume of its worth deserves.

The contents are divided into twenty-six chapters, as follows:

1. Consulting Room and Appointments. Gynaecological Examinations. 2. Hygiene of Infancy and Girlhood. 3. Normal Menstruation. Menopause. 4. Dysmenorrhoea. Dilatation. Menstruous Dysmenorrhoea. 5. Intermenstrual Pain. 6. Amenorrhoea. Vicarious Menstruation. 7. Menorrhagia and Metorrhagia. Extra Uterine Pregnancy. 8. Constipation. Headache. Insomnia. Obesity. 9. Backache. Coccydynia. 10. Acute Infectious Diseases as a Cause of Pelvic Disease. 11. Vaginitis. Vulvitis. Cervicitis. Endometritis. 12. Pruritis. Vaginismus. Masturbation. 13. Displacements of the Uterus. 14. Pelvic Inflammatory Disease. 15. Sterility. 16. Gonorrheal Infection. 17. Syphilis. 18. Abortion. 19. Injuries and Ailments following Labor. 20. Fibroid Tumors. 21. Carcinoma. Diagnosis and Palliative Treatment. 22. Cystitis. 23. Functional Nervous Diseases met with by the Gynaecologist. 24. Appendicitis in Association with Pelvic Disease. 25. Splanchnoptosis. Movable Kidney. 26. Post Operative Conditions.

**Orthopedic Surgery.** By Henry Ling Taylor, M. D., Professor of Orthopedic Surgery and attending Orthopedic Surgeon New York Post Graduate Medical School and Hospital, etc. Assisted by Charles Oglivy, M. D., Adjunct Professor of Orthopedic Surgery, New York Post Graduate School and Hospital, and Fred H. Albee, M. D., Instructor in Orthopedic Surgery, New York Post Graduate Medical School and Hospital, etc. Has 254 illustrations. D. Appleton & Company, Publishers, New York. 1909.

This volume of nearly 500 pages is devoted to the study of deformities by Dr. Taylor and his associates, who have had large experience and great opportunities in this work. The book is interesting from cover to cover and the value of it is greatly enhanced because of the many illustrations which are so necessary for the full comprehension of the subject. The work is thorough, up-to-the-minute, and gives the very latest methods of diagnosis and treatment.

**Diseases of the Skin.** By A. H. Ohmann-Dumesnil, A. M. M. E. M. D. Ph. D., formerly Professor of Dermatology and Syphilology in the St. Louis College for Medical Practitioners; the St. Louis College of Physicians and Surgeon; the Marion-Sims College of Medicine; Member of the St. Louis Medical Society, the Missouri State Medical Association, of the American Medical Association, of the 1st, 2nd, 3rd, 4th, 5th, and 6th, International Dermatological Congresses, etc. Third Edition. Thoroughly revised and enlarged; 140 original illustrations. St. Louis. C. V. Mosby Medical Book & Publishing Co. 1908.

The subject of skin affections is admirably presented by this author in a clear manner and will be found useful by student as well as physician. The first chapters are devoted to the anatomy, both gross and microscopical, of the skin and its appendages its physiology, the pathology, cause, symptoms and diagnosis of its various diseases together with treatment following. The affections encountered in general practice are thoroughly dealt with, and an appendix containing a treatise on diet and food eruptions adds interest to the work. The illustrations are good and serve well the purpose for which each is intended.

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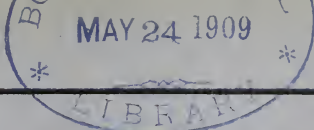
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## CONTENTS

Editorial .....	3
Diagnosis and Surgical Treatment of the More Common Gall Bladder Diseases, by Dr. R. L. Bradley.....	4
Scarlet Fever, by Dr. Walter G. Hope.....	11
Erysipelas, by Dr. C. M. Yater.....	13
Ileus, by Dr. James H. Wroth.....	18
Anesthesia, by Chas. F. Montgomery, M. D. ....	22
Memorial .....	26
News Items and Book Reviews.....	27

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**EDITORIAL**

Following the report of the organization of the Santa Fe society, comes the news that the profession of Colfax County have been called together at Raton, May 1st, for the purpose of organizing the Colfax County Medical Society. We feel confident that the meeting will be marked with success, and that we will soon have a good, strong society in Colfax.

The official call to the Sixtieth Annual Session of the American Medical Association, Atlantic City, June 8-11, has been received.

Our Society is entitled to one delegate, Dr. R. E. McBride, Las Cruces, being elected to represent us as such at the last meeting of the New Mexico Medical Society.

The Sixtieth session will be largely attended and many matters for the future welfare of our organized profession will be discussed. Those of our men who expect to attend will be interested in knowing that Dr. Chas. Wood Fassett, Secretary Medical Society of the Missouri Valley, St. Joseph, Mo., has extended to them an invitation to join their excursion party. A special train, low rates and good service is assured. Those who wish to take advantage of this kind invitation will be furnished with all necessary information by addressing Dr. Fassett.

It is with pleasure we announce the organization of the Santa Fe County Medical Society, a pleasure which we have looked forward to for a long time. On Saturday, April 3rd, twelve good men from different parts of the county met at Santa Fe and perfected a County Medical Society which at once will become one of the strongest and most active of the component societies of our Territorial organization.

Delegates to the New Mexico Medical Society were named, a scientific program for the coming year adopted, and the following officers elected:

President—Dr. W. S. Harroun,  
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The next meeting will be held May 1st, and it is expected that the newly formed society will double its membership at that time.

# DIAGNOSIS AND SURGICAL TREATMENT OF THE MORE COMMON GALL BLADDER DISEASES.

R. L. Bradley, Roswell, N. M.

With the general introduction of the exploratory incisions for all obscure abdominal conditions, our knowledge of the gall bladder in disease, with its many and complex symptoms, has greatly increased. Many cases were formerly erroneously treated for "stomach trouble," appendicitis, typhilitis, and about every other known abdominal disease, other than the true condition.

From our observation, cholecystitis is the primary and cholelithiasis the secondary condition, in the chronic states, as laboratory experiments have proven that sterile foreign bodies, with smooth surfaces, introduced into a normal bladder do not produce cholecystitis nor do they gather salts on their surfaces, unless the bladder is subsequently infected to produce a cholecystitis. It can thus be safely argued that the diathesis known as cholelithiasis is dependent upon a primary cholecystitis, except in the rare possible condition of the diathesis being dependent upon a primary cholangitis.

We also know from experiment that when the common duct is ligated an infectious cholecystitis follows and that a period of not less than six months elapses before stone formation begins. This explodes the old theory that cholecystitis always followed a cholangitis from intestinal infection and proves that when stone formation has taken place and the initial attack of biliary colic is excited by the engagement of the stone in the orifice of the cystic duct, we have a chronic condition. It is not our purpose to deny that an ascending infection is possible

and doubtless many cases of cholecystitis are thus produced.

When considering the ætiology of cholecystitis, many factors must be taken into account and it seems well to divide the cases into simple, ulcerative, suppurative and phlegmonous. The acute, or exciting, cause in all types is undoubtedly infection.

Among the predisposing causes the most prominent is that of sex. About 75 per cent of all cases reported have been females and of these 90 per cent have borne children. Pressure on the common duct by the upward movement of the gravid uterus doubtless leads to infection of the gall bladder. Tight lacing can likewise produce compression of the common duct.

Personally, the majority of our cases have occurred in short, stout women and it would seem these individuals are subject to greater pressure during pregnancy and are more given to tight lacing than their slender sisters.

As age is a factor, most of the cases occurring in women past forty, it is to be presumed that pressure is long continued before inflammation is excited or that the usual progress is very slow after the primary infection.

Some authorities name sedentary habits, rich food, trauma and an abnormal mental condition as predisposing causes.

When cholecystitis is observed in young persons, there is usually a history of typhoid fever and in some stones examined the core has been found to consist of the bacillus typhosus.

Among the bacteria found in the bile removed from the bladder, may be mentioned the bacillus coli and typhosus, streptococcus, staphylococcus, pneumococcus, and in a few instances, the bacillus of tuberculosis.

It is reasonable to conclude that the mucous membrane of the gall bladder is subject to the same ideopathis inflammations as are the mucous membranes in other portions of the body, so we would expect to encounter cases in which the conditions could not be accounted for in any other manner.

Inflammation in adjacent structures would serve as a predisposing cause by involvement by continuity.

In the simple form, the infection is probably by germs much attenuated and the disturbance is mild enough for the bladder to discharge its contents without great effort.

The ulcerative form seems to be due to pressure within the bladder which alters the blood supply and results in degeneration or from continued pressure from tumors of the adjacent structures.

The suppurative form is due to a virulent bacterial invasion, usually the streptococcus or staphylococcus.

The phlegmonous condition, in our observation, appears to be of the moist variety and is caused by occlusion of the veins draining the bladder, the inflammation being intense enough to acutely involve all the coats.

The division we have made is not arbitrary, as frequently the gangrenous form is seen in those cases known for years to have a low grade cholecystitis and some of these chronic low grade cases develop the suppurative form during the course of typhoid or pneumonia.

It is thus to be noted that once a simple cholecystitis is established there is a vicious cycle to be feared in that the conditions are favorable for the engrafting of a more virulent infection and the subsequent change from the simple to the more severe forms.

In considering the symptoms and diagnosis of these forms, the sympa-

thetic nerve supply must be studied. We know from operative observations that the visceral tissues, including the peritoneum, are but poorly supplied with sensory fibers, as witnessed by the absence of pain when the bowel or gall bladder is incised after having been stitched to the abdominal wall incision. This is always done without an anæsthetic and the patient calmly watches the procedure without exhibiting, or claiming to experience, pain. On the other hand, cutting the parietal peritoneum is exceedingly painful.

With this nerve supply in mind, it is reasonable to presume that an inflammation of the gall bladder can exist without much pain, unless of severe enough type to involve the parietal peritoneum or to involve reflexly the sensory fibers.

This view of the nerve supply will account for those cases wherein calculi are found at the time of operation for conditions other than cholecystitis and in which a careful inquiry into the previous history fails to elicit the slightest symptom of gall bladder involvement, yet there must have been a chronic cholecystitis for some time or there would have been no stone.

The sensory fibers of the viscera seem to respond only to pressure, as is seen in the nausea at times produced by palpating a distended gall bladder or duct, or pinching the exposed gut after an inguinal colostomy.

With these facts before us, we can appreciate the reason for so many of these cases being treated for "indigestion," a term which means much to the laity, but little to the doctor.

When the gall bladder becomes the seat of inflammation, the swollen mucous membrane may practically occlude the opening into the cystic duct. The increased blood supply means an increase in the amount of work, so we



find the bladder working under the double disadvantage of trying to force its contents through a narrowed lumen, and at the same time, adding to its contents an excessive amount of mucous, which results in distention.

The pressure and abnormal muscular effort, through reflex action, produces nausea and vomiting, accompanied probably by vaso motor change, which depletes the engorged vessels of the bladder and allows an escape of its contents.

The altered condition of the bile produces a change in the intestinal digestion, resulting in fermentation, which adds to the pressure on the distended gall bladder, so we may find these attacks of nausea and vomiting occurring from one to three hours after eating.

The diagnosis in this pre-colic stage is to be made by exclusion. If nausea and vomiting are due to gastric disturbances, the fluids will be found altered and the vomitus will show lack of digestion. If the condition is due to cholecystitis, the liver will usually be found slightly enlarged and the gall bladder tender on pressure. In chronic gastric disturbances there is usually loss of flesh and a distended stomach. In the simple cholecystitis there is no loss of flesh.

To elicit tenderness, the left hand is placed over the lower ribs on the right side and the thumb pushed up under the costal margin of the tenth rib, the pressure being sufficient to allow the thumb to pass under the margin of the liver. Have the patient relax the abdominal muscles by reflexing the thighs on the abdomen and follow the gall bladder in its upward movement at the time of expiration. This will allow firm contact with the gall bladder on inspiration and, in the majority

of cases, inspiration will be suddenly cut off as the bladder is impinged between the thumb and liver or costal wall.

The diagnosis of the chronic stage is, as a rule, much more easy. The engaging of the stone or inspissated bile in the orifice of the cystic duct is characterized by the intense "doubling up" pain of biliary colic, radiating around the back, up to the right scapula, point of the right shoulder and at times down the right arm and into the neck.

More rarely the pain is referred along the course of the ducts and is most intense in the median line.

There is usually a sharp rise in the temperature, accompanied by chilly sensations, but, as a rule, no distinct rigor. The temperature falls rapidly to normal or a little subnormal.

The paroxysms may last for hours or even days, with slight remissions. In the majority of cases the attack is ushered in without warning, often at night, and the pain leaves as suddenly as it began, due to the stone or inspissated gall falling back into the bladder, entering a dilated portion of the duct, or passage into the duodenum. As a careful examination of the stool after an attack of biliary colic often fails to show the passage of stone and a subsequent operation discloses a large stone in the bladder, we are inclined to believe that in the majority of these chronic cases the stone falls back into the bladder. These seizures may or may not be followed by jaundice.

If the cystic duct becomes occluded, the bladder increases in size, being at first filled with a bile stained fluid, which later changes to a clear mucoid secretion.

Should the common duct become occluded, the jaundice is marked, being a deep yellow and not at all like the

greenish jaundice seen in malignant conditions.

The gall bladder does not enlarge in occlusion of the common duct by stone, except in a very few instances. It is well to emphasize at this point that an enlarged gall bladder, with deep jaundice, means an obstruction to the common duct as a result of pressure from without or from cicatricial contraction of the duct itself and that continued jaundice with a normal bladder, or one contracted, will be due to stone in the common duct.

When the parietal peritoneum is involved in the inflammatory process, the picture is more intense. The local tenderness and pain are increased and the temperature curve is higher.

A continuous elevation of temperature, with abdominal distention and severe prostration, indicates a gangrenous process.

In empyema of the gall bladder the temperature is typical of suppuration elsewhere. The fever is marked by remissions. Rigors are the rule before each rise in temperature and the remissions are accompanied by sweats of relaxation. The local tenderness is marked. The rigors may occur every few hours or they may be twenty-four hours or more apart and simulate a mixed malarial infection.

Should the empyema be associated with cholangitis, jaundice is then a prominent symptom.

Empyema is often mistaken for appendicitis, the pain and tenderness being diffused from involvement of the parietal peritoneum and the abdomen scaphoid so that a satisfactory examination is at times out of the question. In some cases the diagnosis can only be made after incision.

When the gall bladder is enlarged, it can usually be felt below the costal margin. It is to be recognized by its

movement during respiration. In thin walled individuals crepitation can at times be elicited when the bladder contains calculi.

The differential diagnosis must be considered between gall bladder conditions and pyloric and duodenal ulcers, malignant conditions about the pylorus and pancreas, the various benign changes in the liver, pancreas and stomach, renal colic, floating and cystic kidney and gastralgia.

In pyloric ulcer, the tender area is nearer the median line and the pain bears a fairly constant relation to the time of taking food, while in the biliary colic, the attacks are more frequent at night, except in those mild cases of cholecystitis where the parietal peritoneum is not involved and the pressure of the distended bowel cause a sense of discomfort in the region of the gall bladder, with perhaps nausea and vomiting one to three hours after eating.

In duodenal ulcer, the same relationship of pain to time of taking food is observed. In both gastric and duodenal ulcer the collapse is more marked than in biliary colic.

Malignant tumors about the pancreas and pylorus, by pressure on the common duct, produce jaundice, with enlargement of the gall bladder, and cause pain to the right of the median line. The progressive weakness, with wasting, the greenish discoloration of the skin and the insidious onset point to malignancy. An examination of the gastric secretion will clear up the diagnosis in gastric cancer and an examination of the urine will reveal a glycosuria in pancreatic disease.

Tumors of the liver may give pressure symptoms, with jaundice, and the diagnosis remain in doubt until the time of operation. As a rule, the liver enlargement in tumor is greater than

in gall bladder disease and a dilatation of the superficial veins is to be noted, due to pressure on the portal circulation. The cachexia is more noticeable in tumor, there being slight anaemia even in the very chronic cases of cholecystitis.

In the early stages of cirrhosis, the patients may have pain and tenderness, accompanied by jaundice, but a history of alcoholism or syphilis will enable a diagnosis.

In renal colic the diagnosis is to be made by occurrence of pain in the flank at the onset, radiating downward along the course of the ureter and referred to the scrotum and inner side of the thigh; by altered urine, usually bloody, and containing pus and much epithelium.

Floating kidney may be returned to its bed by manipulation and the kidney shape outlined by palpation, except in some cases of malignant disease, where the normal contour is destroyed. In any event the structure is more dense and the examining hand be placed between the tumor and the liver margin and the colon tympany elicited.

In cysts of the kidney inflation of the colon will clear up the diagnosis, a cystic kidney lying behind the colon, while a distended gall bladder is found anterior to the colon.

In gastralgia the differential diagnosis is often a matter of very careful study. Probably the majority of cases occur in those of a neurotic type, hence a careful investigation of the reflexes should be made. After each paroxysm the patient should be carefully observed for slight jaundice, as if this is found gastralgia can be excluded.

When considering the prognosis, it can be said that the mild cases of cholecystitis, as such, are not fatal and do not materially interfere with the usual avocation of the individual, but when

it is considered that in the majority of instances the condition is one of progression, which, if not corrected may lead to chronic invalidism, or even death, these cases should have careful attention and instruction. The diet should be regulated, exercise advised and steps taken to avoid trauma by tight lacing or other means.

When a case is observed that does not improve, but on the other hand grows slowly worse, the earlier the operation the better the opportunity for recovery, as when continual jaundice is present the nerve centers are affected by the presence of bile in the circulation and it becomes almost impossible to get a response to stimulants that will assist in combating shock. In addition the danger of hemorrhage in these cases of jaundice make the prognosis much more serious.

In the ulcerative form, if of slow development, the outcome is usually good in so far as the life of the patient is concerned, as adhesions form between the gall bladder and adjacent structures and protect the general peritoneal cavity from infection. The contents of the bladder may be discharged into the bowel after adhesions have glued the structures or terminate in a biliary fistula.

In the suppurative form the prognosis is good if an early operation is secured. If delayed until a purulent peritonitis is established, the prognosis becomes very grave.

In the phlegmonous form the prognosis is always grave, as a septic condition is usually present before the case is seen by the surgeon. The earlier the operation, the better the chances for recovery.

In taking up the subject of treatment we earnestly recommend the exploratory incision in all doubtful cases where the symptoms indicate a very se-



vere type of trouble, as evidenced by high temperature, excessive tenderness and great prostration.

In the mild cases with constant pain and tenderness, or frequent attacks of biliary colic, suturing of the gall bladder to the abdominal incision (not including skin), opening and draining for a period of ten days is usually all that is required. Careful search should be made for obstruction or foreign bodies in the ducts.

If the gall bladder is found much atrophied and suture to the abdominal wall is out of the question, the gall bladder can be closed by the Czerny-Lembert method, if the ducts are found patent. Should the history show the presence of other than a very low grade of infection, drainage must be established through a stiff piece of rubber tubing held firmly in place by means of a purse string suture and the abdominal cavity well protected by gauze packing. Within forty-eight hours the packing can be removed as the drainage tract will then have been well walled off.

Coming to the various steps of the operation for gall bladder disease, it is well to emphasize that the preparation must be as thorough as is possible, remembering that careless antisepsis and the failure to maintain asepsis may cause reinfection with the engrafting of a more virulent infection than the one existing at time of operation.

If the gall bladder be enlarged and in an abnormal position, the incision is made over the tumor, care being taken to provide for delivery so the ducts may be fully exposed for examination.

A sand bag is placed under the patient to increase the space between the pelvis and the costal arch and form a double inclined plane which causes the liver to gravitate toward the thorax and the intestines toward the pelvis,

thus giving a better view of the operative field and more room in which to work.

The incision used by us in normal cases is made downward and inward over the tenth costal cartilage; the incision being about four inches in length. When the right rectus muscle is encountered, it is retracted toward the medium line and the deeper structures divided in the same direction as the skin incision. By not incising the rectus the strength of the abdominal wall is maintained to a better degree, hence less opportunity for hernia. All bleeding is checked before the peritoneal cavity is invaded.

After incision of the peritoneum, all adhesions, if any, are broken and the gall bladder and ducts fully exposed. Should a gangrenous condition be encountered, the margin of the liver must be turned out to fully expose the field of operation. Lateral incisions and division of the ninth and tenth cartilages may be necessary in some cases to effect delivery.

To deliver the liver the anterior margin should be grasped, with gauze between the liver substance and the hands, and the right lobe rotated and dragged downward and inward until the under surface of this organ is made to present anteriorly in the abdominal incision. This will enable a thorough inspection of the gall bladder, ducts and adjacent tissues and permit a thorough removal of all diseased structures.

The peritoneal cavity must be well protected by gauze packing, bearing in mind that more than 90 per cent of all cases reported to date have shown infection.

It is our custom to place traction loops through the serous and part of the muscular coats of the bladder with which to draw it well up into the

wound as its contents escape. A trocar is then introduced in a dependent part and the fluid contents drained into gauze sponges. While drainage is taking place, the bladder and beginning of the cystic duct is explored and any stone found is worked toward the fundus so as to facilitate removal when the bladder is incised.

After removal of the fluid, the bladder is incised by knife or sharp scissors and the cavity gently cleaned by means of small gauze sponges, foreign bodies being removed by fingers or spoon.

The ducts are then carefully explored, preferably with the finger, for stone or cicatrix.

After thorough cleansing and removal of foreign substances, the soiled packing is removed and a thin strip of gauze placed below the bladder and abdominal incision. The parietal peritoneum is then sutured around the gall bladder, the gauze strip being removed as the closure is effected, and the bladder sutured to the abdominal incision below the skin margin. A purse string of ten day gut is then introduced into and through the serous and part of the muscular coat of the bladder and drawn tightly around a stiff rubber drainage tube, which is placed well up to the orifice of the cystic duct.

Adhesions rapidly form which anchor the gall bladder, with drainage opening well extra peritoneal, to the abdominal wall. The tube is removed on the tenth day and the normal flow is soon re-established, unless a careless attention to the wound has allowed reinfection, in which case a biliary fistula may result and necessitate a second operation for its cure.

In the ulcerative form the mode of procedure depends upon the extent of the degeneration. If there are many points of thinning, amputation had best

be done. The technic is about the same as for gangrene and will be described later. If the amount of ulceration is limited and the serous coat is in good condition, simple drainage is all that is required.

The peritoneum is incised around the fundus of the bladder and downward to the cystic duct. Blunt dissection will give less active hemorrhage than a cutting removal of the bladder from its fossa. When the duct is reached, provided the gangrenous process does not involve more than the bladder, amputation is made, clamping the distal portion of the bladder to prevent soiling the peritoneum. Before severing from the duct, a cuff of peritoneum is thrown back and the duct cut close to the reflected cuff, being tied with fine gut to prevent leakage at time of amputation. After removal of the bladder, the cuff is rolled over the stump of the cystic duct and sutured with fine gut. The hemorrhage from the bladder fossa is controlled by compression with hot sponges and the severed arteries by ligature. The reflected peritoneum is sutured to cover in the raw surface left by the removal of the bladder. As these cases are highly septic, good drainage must be provided and continued until the temperature and pulse indicate an abatement of the active stage, or until the adhesions are firmly organized to protect the general peritoneal cavity.

In conclusion we might state that, while no hard and fast rule can be laid down, it is well to refuse to operate on those late cases giving a history of continual deep jaundice extending over a period of ten days or more, and where the septic rigors are occurring every three or four hours, as in our observation, these cases invariably succumb in less than twenty-four hours, never

rallying from the shock. While death was inevitable in any event, the family and friends do not always look at it in this light and their comments are often "it might have been different had we not had the operation," and thus, without malice, prevent an early operation in future cases.

### SCARLET FEVER.

By Dr. Walter G. Hope, Albuquerque.

An acute, infectious, specific and contagious disease. The infection exists from the earliest symptoms and continues long after convalescence has been established. The disease is usually ushered in by vomiting and sore throat, accompanied by fever. The pulse rate will be accelerated and there is usually on the second day a distinct eruption visible.

The distinct specific cause of scarlet fever is unknown, in spite of immense scientific work.

The onset is usually very sudden. In very young children the attack may be preceded by a convulsion. Vomiting is an early symptom. The tongue has a whitish fur and the papillae will be found elevated and very red. It has the so-called "strawberry" appearance. The throat, especially the tonsils, will be found intensely congested and ulcerated, pulse quicker, temperature elevated.

The submaxillary lymphatic glands at the angle of the jaw are swollen and tender. There is usually albuminuria. The rash appears usually within the first twenty-four hours. It is first seen upon the neck and chest. It is a bright scarlet flush. A point to note is that in contrast with measles and small pox, it is much less marked upon the face and cheeks.

*Duration of desquamation:* This

varies greatly and is influenced greatly by the severity of the infection and the intensity of the eruption. It persists longest where the epidermis is thick, as about the hands and feet.

So long as a single flake of necrosed skin remains, the patient may be a source of contagion. The length of time for complete desquamation may be from six to eight weeks. It may be of shorter or longer duration, however. Repeated desquamation is not uncommon, so that we can say there is secondary and frequently tertiary desquamation.

*Scarlitina sine angina:* This form of scarlitina has very slight throat symptoms or so insignificant as to appear almost absent. Usually a faint eruption is present early in the disease. The tonsils are not enlarged but there is an almost constant enlargement of the papillae at the tip and margin of the tongue.

*The Throat:* Streptococci are usually found in the throat during a course of scarlet fever.

Many bacteriologists agree that the Klebs Loeffler bacillus is usually absent, though there are many cases of true diphtheria complicating scarlitina. When the false membrane is found it should be treated as a case of true diphtheria.

Middle ear complications, by extension through the Eustachean tube are common. About 20 per cent of cases are complicated with middle ear inflammation. It is important to examine the ear when high fever persists through a case of scarlet fever. The drum membrane should be punctured if symptoms of pus in drum. Empyema of the mastoid occurs in a small percentage of cases and should be watched for carefully.



*Scarlitina Synovitis*: So called scarlitinal rheumatism is occasionally met with.

Hoge found 117 cases of synovitis out of 3,000 cases studied.

The synovitis is divided into the simple catarrhal or serious synovitis, and the suppurative.

*Kidneys*: There are three forms of involvement of kidneys in scarlitina. First: Simple transient albuminuria; second, septic nephritis; third, past scarlitinal nephritis. Transient albuminuria in three-fourths of all cases of scarlet fever. It does not differ from the "febrile albuminuria" seen in all acute, infectious diseases associated with high temperatures. (Fisher.)

*Septic Nephritis* Develops from the intensity of the infection, caused mainly by the Streptococcus.

*Past Scarlitinal Nephritis: Treatments*: At the Riverside Hospital, N. Y., 500 to 1,000 diphtheritic antitoxine is given as a diphtheria prophylactic measure. Antistreptococcic serum has its advocates and detractors.

The first thing to do in a case of scarlet fever is to isolate—remove all healthy children and adults. If possible, patient should be given an airy south room. The room should be kept well ventilated. Bed linen should be frequently boiled. Paper napkins should be used—never should handkerchiefs or cloths. Toilet paper answers all purposes for mouth and nose. This paper should be immediately burned or thrown into a solution Bichloride of 100 or carbol. Urine and feces can be disinfected by liq. copporas or bichloride H. G.

Temperature room should be from 65 to 72 degrees.

Patient should have at least two daily spongings. Patient should be

anointed once a day with carbolated oil.

The secretions should all be kept free. Lemon juice, in the form of lemonade, is very useful in stimulation of the secretion of urine. I have always seen the best results from keeping the bowels loose and the kidneys active. That we eliminate toxic matters in this way all agree. If heart becomes weak strychnine is indicated; also digitalis, both for its action on heart and kidneys; alcoholic stimulants are tolerated in large doses.

*Nose and Throat*: Irrigate nostrils from fountain syringe with normal salt solution. Have bag of syringe not more than one foot above child's head.

*Nephritis*: When the first symptoms appear, we must aid the kidneys, skin and bowels by eliminative treatment. The child must be kept in bed, well blanketed. The diet should consist of milk, milk and cereals, buttermilk. If the stomach be irritable, the milk should be peptonized. To stimulate diaphoresis hot baths aided by hot packs will be serviceable. For thirst ice, whey, lemonade, or orangeade. The baths should be 100 to 110 degrees. Child should be immersed five to ten minutes, should be rubbed gently while in bath. When taken from bath, place child between hot blankets, either wet or dry, for one hour. If blanket be wet, a dry blanket should cover it, and better, an oilcloth over dry blanket.

Hot saline injections into colon, will stimulate diureses and aid in the elimination of toxins; temperature of saline should be 110 to 115 degrees.

Restorative treatment, such as iron, strychn., malt extract, cod liver oil, after symptoms of nephritis subside. The child should be kept well protected for at least two months after the first symptoms appear.

**ERYSIPELAS.\***

(By Dr. C. M. Yater, Roswell, N. M.)

Erysipelas is an acute infectious disease characterized by inflammation of the skin and often the subcutaneous tissues, accompanied by the usual symptoms of inflammatory conditions elsewhere, variously modified, and caused by the streptococcus of Fehlisen. In the early days of medical investigation and even down to the latter part of the nineteenth century, it was said and thought to be due to a vitiated condition of the fluids of the body, especially the bile; and that the inflammatory condition of the skin was only a local manifestation of the general diseased condition of the body fluids. We know now that what was then considered a local manifestation of a general constitutional disease, is in reality, the disease itself; and the general constitutional disturbance only a result of the acute local infection. The causative factors of erysipelas have been so thoroughly threshed over during the past twenty-five years that it is now generally considered by the best authors that the streptococcus of erysipelas is identical with and cannot be differentiated from the streptococcus pyogenes. It is said by bacteriological investigators that, while the streptococcus grows well in the air, it grows equally well, if not better, anaerobically. One investigator of note (Achalme), claims that those germs grown anaerobically show more activity than those grown in the air, and that the streptococcus is in reality a facultative aerobe. While we cannot have a true erysipelas without the causative influence, of the streptococcus, there are undoubtedly other causes, or, I might say, factors, which

are predisposing in their nature. Anything, either temporarily or permanently weakening the tissues of any part of the body, which part might be exposed to the action of the streptococcus, predisposes that part to erysipelas.

Along this line I would mention over-work, starvation, fatigue, mental strain, or indeed any intemperate excess. There is one condition which, in my opinion, we must necessarily have before it is possible to have a streptococic infection; and that is, there must be a solution of continuity in the part, or in the immediate vicinity. Operations or solutions of continuity from any cause whatever, including the umbilical stump and the post partum uterus, all furnish possible avenues for erysipelalous infection. In the first years of my connection with the medical profession, erysipelas was divided into "idiopathic" and "traumatic". Modern investigation into the causation and pathology of erysipelas, has served to expose the fallacy of such a classification. While there may be no visible wound or solution of continuity in the affected part; from the fact that the now recognized cause of erysipelas is the streptococcus, and from the further fact, that, for this germ to gain access to the body, there must be a solution or continuity: it is reasonable to suppose there is a wound, however small, somewhere in the neighborhood. If not in the skin itself, possibly in the mouth, eye, ear, nose, or some neighboring mucous membrane. The tonsil, from its structure being a natural and permanent wound, must not be lost sight of as an avenue for the entrance of the infection, as it is indeed for many other pathological germs. The loss of the epithelial layer of the skin or mucous membrane, or the loss of vitality in the epithelium, while not strictly speaking a solution of continuity, is such in reality; and may serve as a point for a

\*Read by title at meeting of New Mexico Medical Society, Albuquerque, September 3, 1908.

violent erysipellatous infection. Since the establishment of antiseptics, contagion does not play so important a role as formerly. Erysipelas is now rarely ever seen to spread in a hospital, and when it does, it is easily traceable to mismanagement. In pre-antiseptic days it was the one thing to be dreaded in the surgical wards of a hospital where one case had made its appearance. Atmospheric conditions in a measure influence erysipellatous infection. We see more cases in times of low, moist, rapidly changing temperatures. I shall not deal very extensively with the pathology. In life it presents the ordinary phenomena of inflammation. Where it attacks the skin it often passes on deeper into the tissues, when we have the phlegmonous or necrotic form. When the cocci have invaded the deeper tissues, it runs a much more severe course, and spreads more rapidly than when confined to the skin, owing to the looseness of the areola tissue, which offers but little resistance to the inroads of the cocci. It does not always stop at this, but often borrows along the course of blood-vessels, nerves and in the intermuscular spaces, where the cellular tissue is loose for great distances, and will invade the muscles themselves and even bone, causing large sloughs and gangrenous changes. It is now generally conceded by the best authors that the cocci do not enter the blood current, but are often transmitted long distances by the lymphatic vessels. There is no special recognized stage of incubation in erysipelas, but one which is common to very many infectious diseases, such as, general malaise, anorexia, emul, perhaps from a light fever there may be a feeling of exhilaration. It is claimed by some authors that in cases where the exposure to other cases was known, the incubative period ranged from fifteen to sixty hours. The first symptoms of

any note, and one which is rarely absent, is a chill, in character not unlike a severe malarial chill, or the initial chill of lobar pneumonia, closely simulating the chills of septic infection, which, in reality, it is, or is a very near relative. The severity of the chill furnishes a tolerably fair index to the severity of the attack to follow. Along with the chill, or immediately after, there is a considerable rise of temperature, going frequently as high as  $104^{\circ}$  or over, and often accompanied by considerable delirium. The pulse has nothing in it uncommon to other fevers. Headache is almost a constant symptom, and especially in those cases where the erysipelas spreads over the hairy scalp. There is nothing characteristic about the temperature, and no direct relation between the height of the fever and the extent of the disease: however, a constant elevation of temperature gradually increasing, usually precedes a fatal termination, and the temperature sometimes continues to rise after death. All these symptoms may make their appearance and continue for a day or two, and in facial erysipelas, the sub-maxillary lymphatic glands will be found tumefied and tender, before the characteristic appearance of erysipelas is shown on the skin. It is practically impossible to make a positive diagnosis prior to this time, after which occurrence, there can hardly be room for doubt. During this formative stage, erysipelas has been mistaken for typhoid fever: but in this day and time, no well-informed physician would venture a diagnosis of typhoid fever short of watching the case four or five days. In that time the case, if it be erysipelas, will have introduced itself. The first visible manifestation of the disease is in the skin, in the form of an acute inflammation. A zone is formed, which increases very rapidly, often spreading to double its size in twenty-four hours.



This zone presents quite a characteristic appearance, being generally of a bright scarlet hue, though the shade varies in many cases from a bright scarlet to a dark rose color, and in pale, anaemic persons there may be only a blush. Drawing any hard substance across the inflamed area, will leave in the wake a white line, which quickly resumes its former color. The skin soon becomes tense, glistening and hot, with a sensation of burnin~ and itching. The inflamed area is quite painful, especially upon manipulation, and is elevated above the surrounding skin, due to the swelling in the part, the outline being sharply defined. The greatest intensity of the inflammation is usually at the outer margin, it not being uncommon to see the inflammation subsiding in the center, or at the point first affected, while still spreading on the periphery. In locations where there is much loose areola, as for instance, under the eye, the pain is not usually severe, while the swelling may be enormous; but where the skin is tightly drawn and firmly attached to the underlying structures, there we will find the greatest intensity of pain, with comparatively little swelling. We often see the spread of erysipelas arrested upon reaching a point where the skin is firmly attached, as for instance, around the edge of the hairy scalp. We have all no doubt seen cases of facial erysipelas spread rapidly till it reached this point and go no further. Generally when the progress of the disease is arrested, there is a rapid fall of temperature to the normal, which, however, rarely occurs before the fourth or fifth day. In very severe cases, or where it has assumed the phlegonous form, the fall of temperature is more apt to be by lysis. It is well in treating a case of erysipelas to be constantly on the lookout for trouble, as it is not uncommon to see a simple erysipellatous inflammation of the skin, suddenly as-

sume the phlegonous form, and develop severe subcutaneous ravages with enormous destruction of tissues, accompanied by violent symptoms, not infrequently causing the death of the patient, either from a violent toxæmia, or a constant drain upon the vital forces. Many complications may arise in the course of erysipelas. We may have a septic meningitis develop from eye, ear or nose involvement. Dyspnoea may be a serious complication, caused by the disease extending into the larynx, and where there is oedœma of the glottis, which we occasionally have, the result is usually rapidly fatal.

A case is reported (Rendu) where erysipelas was thought to have traversed the alimentary canal, starting in the mouth and making its appearance at the annus, causing a large perinaeal abscess. Another case is reported as having started in the perinaeal region and extending up the entire length of the large intestine (Ivanowski). Peri—and endo—carditis, neuritis, pleurisy and peritonitis are mentioned as occasional complications of erysipelas. The diagnosis of erysipelas is oftentimes difficult, if not impossible, before the characteristic redness makes its appearance, especially where a mucous membrane is the seat of the primary infection, as for instance, in the nose or mouth; but the high fever with swelling and tenderness of the neighboring lymphatic glands, will furnish very presumptive evidence of the nature of the condition to be met, especially in the absence of any other appreciable cause for the symptoms. On the surface of the body, as before stated, it is not likely that a careful diagnostician will be often mistaken.

Just here I would pause to caution those who might be too hasty in making a diagnosis, not to be too ready to pronounce as erysipelas every red and tender spot that may be shown you.

You might make yourself the subject of ridicule sometime by diagnosing as erysipelas, a bee or wasp sting. Such circumstances have happened to competent but hasty men. Ascertain everything there may be in a case before expressing an opinion. Even then you may have reasons for postponing your diagnosis. As a general rule erysipelas tends toward recovery. That which is to be dreaded, and which influences the prognosis most, are the complications. If it appear in the mouth or nose, disastrous results may follow, in the way of glottis, etc. Or, if the vagina is the part affected, in the puerperal state, we may, and most likely will, have to deal with a puerperal septicaemia of a most virulent type. When erysipelas attacks the umbilical stump in the new-born, it usually terminates fatally. Erysipelas occurring in the course of other diseases of the skin of a chronic nature, especially tubercular and syphilitic diseases, has often been a source of relief from these conditions. Malignant growths, as carcinoma, sarcoma and epithelioma, it is claimed, have been relieved or cured by an intercurrent attack of erysipelas in the part. I have nothing new to offer on the treatment of erysipelas. When it is confined to the skin, it is not generally necessary to resort to any internal medication, more than to see that the bowels are kept open. However, where the fever runs high, aconite, veratrum, large doses of quinine or small doses of phenacetine may be advantageously administered. Headache and delirium may be met with potassium bromide and chloral hydrate to induce sleep. Cooling lotions to the inflamed area are very grateful to the sufferer. Compresses out of ice water may be applied every few minutes. The traumatism, if discernable, should be treated on general surgical principles. In cases seen early, I have often resorted to a

treatment which has given uniformly good results. First cleanse the part thoroughly with warm water and soap, treat the wound surgically, after which paint the inflamed surface, and even some distance beyond the margin, with pure carbolic acid, waiting a few moments till it assumes the characteristic whiteness, when it is bathed in alcohol to stop the further action of the acid on the tissues. After this a piece of gauze wet with alcohol is bandaged on the surface. This in this great majority is all there is to it. When the dressing is removed the next day, the surface will have lost the redness and swelling, presenting a wrinkled appearance, and in a few days the epidermis will peel off and the patient is well. Generally it will not be found necessary to put on a second dressing. Of course this plan of treatment is applicable only to small surfaces. Where the surface covers too extensive a field, some other treatment must be adopted. A treatment which I have often adopted, and one which is very grateful to the patient is, to paint the inflamed surface several times a day with a mixture representing equal parts of Tincture of Iron and Glycerine. It soothes the burning pain, and often the patient will drop off into a nice, refreshing slumber after the first dressing. The Nitrate of Silver and Iodine treatment I have found too painful to be employed, especially when we have so many other remedies which are equally as good, if not better, and which are not painful at all.

The latest thing out (to my knowledge) is, a 50 per cent watery solution of ichthyol painted all over and some distance beyond the inflamed area every four to six hours. If the patient is restless or delirious, in addition to the proper remedies to meet these conditions, the ichthyol should be applied in a more adhesive form, or mixture. The formula recommended by Unna is a

very good one. It consists of Ichthyol 40 parts, starch 40 parts, egg albumen one and a half parts, and water qs. 100 parts. This makes quite an adhesive dressing. I have prescribed the ichthyol treatment quite a number of times in the last few years, and always with very gratifying results. When we come to deal with the phlegmonous form we must meet it energetically and heroically. Free incision, as long and as deep as the infection extends, must be practiced early. Free drainage, strong antiseptic measures, and looking well to the proper support and nourishment of the sick one, is about all there is to be done. We are advised by medical writers, that, inasmuch as erysipelas is a highly infectious disease, the utmost caution should be employed to prevent it being transmitted to others. This may all be well enough in the surgical wards of hospitals, and indeed it is; however, in private practice, the isolation of the patient is not always convenient, nor is it indeed so necessary. Of course, ordinary neatness will, and should be enjoined, not only in these cases, but in all other. So far as my experience goes I have never seen the disease spread in a family, or a case developed from having come in contact with another case, although in many instances the family and friends have been in constant attendance. To be sure, had I a wound on my hand, I would, in treating a case of erysipelas, be very cautious, so as to avoid infection. The physician who does obstetrical work should be extremely cautious when called to a case of this kind while in attendance upon a case of erysipelas. I think there is no reason why we should not accept obstetrical engagement while in attendance on these cases, if we are thorough in our antiseptic toilet before coming near the lying-in chamber. This should consist of a bath from head to foot with hot water and

soap, paying especial attention to the hair and beard, a change of clothing from the skin out, and a thorough antiseptic cleansing of the hands, arms and finger nails with a 1 to 1000 solution of bi-chloride or mercury; with lysol or some other strong antiseptic. With such precautions as these I consider the danger of infecting the woman as practically nil. Complications arising in the course of a case of erysipelas must be dealt with as we would under any other circumstances.

Now, gentlemen, I shall be pleased to hear a free discussion of this subject, as by the exchange of ideas gathered by study and experience, we can materially aid each other in our glorious, but often unappreciated, labors for the amelioration of the sufferings of humanity.

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#### SENN CLUB.

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At the meeting of the Senn Club, held March 26th, it was decided to perpetuate the memory of Nicholas Senn and to bring before the public, lay and professional, the valuable services rendered by Dr. Senn. The means to be employed for this purpose will be decided on later. Dr. Alex. Hugh Ferguson was unanimously elected president of the club, and Dr. Arthur MacNeal was re-elected secretary.

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Engagement announced without names. An eminent nerve specialist who is a member of the Society, is being congratulated by his friends on his approaching marriage to a prominent Albuquerque matron.

Our friend has lately ensconced his rotund figure in a frock coat, and receives patients at his offices in the N. T. Armijo Building with a smile that never fades.



### ILEUS.\*

By Dr. James H. Wroth, Albuquerque.

The name Ileus is one of those unfortunate medical terms which in no way describes or gives the hearer any idea of the pathological conditions involved, and which has, from its very uncertainty been applied to various and different conditions by different authors. The definitions of this term as compared with the conditions to which it has been applied are equally vague and uncertain. Gould says it comes from the Greek "to roll" and that Ileus is "volvulus" and is a synonym of the so-called Iliac passion, giving the symptoms which are now the classical ones of this disease.

Dunglison gives practically the same definition as Gould. Quain, in his dictionary of Medicine considers Ileus a synonym for intestinal obstruction. An equal uncertainty as regards this definition exists among the writers of surgical works. Dennis, Fowler, Keen, Tillman, McDonald, Wyeth—none of these allude to it under this name. Senn while indexing it as "Ileus" "intestinal obstruction," and refers all his statements regarding this affection to that subject in his index.

Murphy does not consider Ileus as a pathological disease, but rather as a train of symptoms, in which all other authors agree with his as to the symptoms predominant, that is, first—abdominal pain; second, vomiting or stoppage of the intestinal contents, whether gas or solid. It will, therefore, be seen that the name itself is misleading. That it undoubtedly and originally came from the location of the various symptoms will probably not be denied, but its existence is with us and for reasons best known to persons

employing the term it has come to be applied to that train of symptoms mentioned above, which follow operations on the abdominal cavity. In fact, Dunglison in his edition of 1866 mentions the fact that it is more apt to occur after hernias or ovariectomy, thereby foreshadowing the future trend of surgical ideas.

We may safely say, therefore, and in this paper it will be so considered, that the term Ileus is confined to those conditions of intestinal obstruction or intestinal stasis occurring after operative procedure upon the abdomen, the same whether obstruction or stasis because the symptoms gross and material are the same in either case.

As regards the causation of Ileus authors differ, some, like Mikulicz dividing them into purely "dynamic" and "mechanical;" and others, mainly among Americans, into "dynamic," "adynamic" and "mechanical." To these has been added another division that of the "mechanical" septic and "adynamic," but all these divisions are purely the fancies or theories of the author, and could be contracted or extended to suit the individual requirements of the case, especially when we consider the definition given by most authorities of "dynamic" Ileus, where the obstruction is supposed to be due to an excess of power. All authorities agree, however, that the adynamic form of Ileus has its existence from any condition causing the absence of power of propulsion of the contents mainly due to difficulties or defects of innervation or circulation.

It, however, is impossible to make any positive distinction in causation, as all of the causes may be present in one and the same case. What we are most concerned with as surgeons is the ability to recognize this condition, and yet the symptoms as taken are

\* Read before Bernalillo County Medical Society.

all of them not only liable to misinterpretation, but are frequently devoid of meaning. The location of pain, the character of pain, tenderness and swelling, distended coils of intestine, local areas of dullness or tympany, the character of the vomit, examination of the urine and blood, the audible gurgling—are all of great value taken collectively, but individually no one of them is of any diagnostic importance.

This may be illustrated by the impaction of stone in the cystic duct. When the stone passes into the duct there is produced a pain that is colicky, there is the absence of peristalsis and with frequent vomiting, the one particular point with a pain of the cystic duct obstruction and the pain of mechanical Ileus is that with the pain of the cystic duct obstruction has been the absence of gurgling or rumbling in the bowels. Not only can this usually be heard by the stethoscope, but is frequently audible to the bystander. The one is paralytic Ileus, stopping the intestinal way and producing symptoms of reflex causes producing reflex paralysis of the intestine, the other is the colic of the mechanical Ileus and the pain that is endeavoring to remove intestinal obstruction by forcible pressure, and is accompanied by rumbling of wind.

Ovarian compression has been diagnosed as mechanical Ileus and up to a certain point, properly so.

Another case in which, mainly in children, there is a persistent distension of the belly, pain is complained of all over the abdomen, there are no bowel movements, there is absence of peristalsis, and there is the same absence of sound through the stethoscope as there is in paralytic Ileus, but there is always present in this class of cases what never occurs in primary obstruction of the intestines, and that is ele-

called attention to the fact that many of the symptoms of Ileus were produced by the ligation of pedicles and since the practice of ligating pedicles en masse has ceased we are having less vomiting and fewer cases of paralytic Ileus than formerly.

It is understood that the term paralytic here is synonymous with adynamic given in the definition above. These conditions prove the reflex character of the disorder. Peritoneal injury due to excessive handling or prolonged exposure is another cause and a most important one. In the strangulation stage of appendicitis there are all the manifestations of paralytic Ileus. In general peritonitis there is a condition which is difficult to differentiate from mechanical Ileus. The general peritonitis produces obstruction of the bowel in proportion to the inflammation of the bowel wall, later on producing adhesions which in their turn keep up the symptoms already formed. Fractures in upper dorsal region, gun shot and stab wounds, of the spine, all produce a form of adynamic Ileus or paralytic. Surgeons of late have been calling attention to the fact that all cases involving injuries to the mesentery, whether operative or traumatic, are all productive of this form of Ileus and are practically fatal. In the removal of tumors from the mesentery and on the ligation of nerves and blood vessels of the mesentery, unless exceptional care is taken, the foundation is laid for paralytic Ileus, which in the majority of cases has been fatal.

Murphy states that he has been surprised to find that no value can be placed on the leucocyte count in these cases. He states that he has seen a 36,000 count in mechanical Ileus and a 7,00 count in a case of septic peritonitis, reversing the condition that he expected to find.

Simon of Johns Hopkins, in a series of experiments arrives at the same conclusion and states that neither the absolute or relative count will "per se" suffice to differentiate a simple obstructive Ileus from an inflammatory condition of the peritoneum.

Formerly much importance was attached to the examination of the urine. It was hoped, according to the encouraging report of Jaffa that the presence of increased amounts of indican in the urine would be a diagnostic aid, but it has been shown since that this substance is present in increased amounts in certain constitutional diseases, for instance, anemias, starvation, empyema, cancer of the uterus and stomach. In fact, it can usually be obtained in increased amount where any extensive suppuration is going on in the body.

Reversed peristalsis has been considered as the cause of the persistent vomiting, but the researches of Magendie and Mall seem to show that the abdominal muscles are very largely concerned in its production.

At present there is no explanation to be given regarding the rapid formation of gas inside the intestine. Physiologists are strangely silent as regards its production. When we consider the fact that the air normally found in the intestine may have two sources, first—by being swallowed, in which case the oxygen would be rapidly absorbed by the blood while the hydrogen would probably be found in the bowel; second, gas produced by fermentation, mainly hydrogen and nitrogen. Most authorities agree, however, that this distension is due to the fact of the inability of the muscular coat of the bowel to produce onward movements of the contents of the bowel, and a cessation of osmosis.

As explaining the restlessness and great prostration produced by this dis-

ease, Nesbitt and Clairmont both believe it to be due to the formation of poisonous substances by bacterial action, as nuerin has been found in almost all cases of Ileus and in its action it is very much like masearin having a paralytic action upon all untripped muscular tissue, and for this reason they attribute the good results of lavage on account of mechanically lessening the amount of poisonous matter, and call attention to the fact that caution should be used in the use of certain foods, such as eggs, which are rich in the basic principle that under bacterial action may produce neurin.

Regarding the causation of mechanical Ileus of which adhesions or bands of lymph are possibly the most active agents, Finney of Baltimore, on reviewing the large number of so-called reasons either for or against the formation of such adhesions and their subsequent disappearance, says that this as a matter over which the surgeon has but little control, that the surgeon may do a certain amount towards preventing their formation, but it is impossible to prevent them altogether.

Baisch, a German, reports a series of experiments the results of which tended to show that the formation of adhesions is dependent upon the quantity of blood left in the peritoneal cavity after operation. His conclusion is supported by the statistics of Zweifel and seems to indicate some truth in his statements.

These statistics show out of 800 Laparotomies there were only two cases of Ileus, both of which occurred in cases showing extensive adhesions at the time of the first operation. As regards the presence of fluids such as saline solutions, the results are extremely doubtful owing to the rapid absorption. Mayo in his statement says that the presence of a large quan-



tity of fluid in tubercular peritonitis prevents formation of adhesions and this is probably correct from the fact that the absorption in that case is very slow and the amount of the fluid large. The two conditions are not at all analogous. From all this it would seem that the diagnosis of Ileus must be made from a careful consideration of all the symptoms and not by dependence on any one or two. Pryor and Dudley have therefore taken the ground that in view of the difficulty in making a diagnosis between the varieties of Ileus that all cases should be treated in the beginning as though they were adynamic, proper attention to be paid at once to the nervation and circulation, and these done as soon after the operation as possible, especially as no harmful effects can be manifested and there is no masking of subsequent symptoms should the case be other than adynamic.

While Ileus may occur at any time both early and late, statistics show that about 60 per cent occurs before the patient leaves the hospital, and 40 per cent afterwards. Naturally the late cases are those due to a mechanical cause.

Treatment necessarily depends upon causation. From a summary of the various forms of treatment as laid down by different operators, it might be stated that as soon as possible after the operation efforts should be made to restore the defective nerve supply to the mesentery. Whether we consider this as intestinal shock, whether it is the effect of anesthetic or of local origin, all authorities agree that this precaution should be taken in the form of nerve stimulant and preferably in advance of any trouble, even if no evidence of Ileus appear.

Granting the theory of Simon as to the poison eliminated by the bowel it

would seem that strychnia and eserine—the later from its decided effect upon the unstriped muscular tissue; and the former by its stimulant effect upon the spinal centers, are probably the two classical remedies. While treatment in most cases might be considered, it is certain that any other form of Ileus than the mechanical is almost always connected with the inflammation of the peritoneum either circumscribed or wide spread. Halstead seems to believe in this connection that the great majority of cases are a combination of the adynamic form with a slight peritonitis, and a marked absorption of toxins manufactured in that part of the bowel affected.

Most authorities save Kelly, agree that early action of the bowels after an operation is of questionable value, and in fact most of them seem to think that it is contraindicated in a large percentage of cases. All of them unite in stating that atropine is of little or no value. Most authorities recommend change of position frequently made, and from the context of their writings I would imagine that reversal of Fowler's position would be the one most considered, as in the cases reported where position is recommended the autopsy of the fatal cases proved the small intestine to be pushed well down into the hollow of the pelvis and held there by inflammatory action. Should these medical remedies prove of no avail an operation is called for, the details of which it is not necessary to state to a Society like this.

I would like to call attention to both Kelly and Finney of Baltimore. In a personal communication they say they believe they have saved life by the establishment of an intestinal fistula where a more extensive operation was out of the question. Unfortunately this secondary operation does not

present an attractive mortality; in nine cases performed at Johns Hopkins five died.

Regarding the effect of drainage in the production of adhesions and of mechanical Ileus it is interesting to note that the percentage seems to be about the same in all reports. About 60 per cent of adhesion cases, were drainage cases and 40 per cent undrained.

In offering this paper to the Society I regret extremely the choice of this subject, it being one concerning which there is even today a very decided difference of opinion among surgeons, not as to how to treat it but as to what it really is. We are too apt to confuse the various causes of these conditions and consider them as distinct and separate entities, whereas if we could only recognize the fact that there is no method to differentiate between the several causes and that any intelligent treatment must be directed first—in a precautionary way against what might happen rather than what has happened, and then be prepared to follow this up by a radical operation recognizing that in cases of this kind there is not only an anatomical difficulty, but also a chemical poison that we have to deal with. Taken as a whole it is one, if not the most formidable complications that surgeons have to meet and that if experiments and theories of trained observers in this line are correct, it is a plea for cleaner surgery, less drainage and an unusual precaution against Laparotomiesthere were only two cases waste blood.

#### ANESTHESIA.\*

By Charles F. Montgomery, M. D.

We usually associate Surgical Anesthesia with the advent of nitrous oxide, ether and chloroform, by inhalation, about the middle of the nine-

teenth century; but the Assyrians prevented the pain of circumcision by pressure on the vessels of the neck, which was certainly an ancient discovery of the possibility of producing unconsciousness by pressure on the carotid artery and the pneumo-gastric nerve about which we have heard in recent times. Herodotus records the use of druge by inhalation; it must have been very imperfect, judging from the statement, "Vapor from a sponge moistened with warm water which had been previously steeped in a decoction of opium, belladonna, hyoscyamus, mandragora, hemlock, ivy and lettuce." The early history of nitrous oxide, ether and chloroform anesthesia, contain conflicting statements in regard to who discovered and first used each. It is generally stated that Wells first used nitrous oxide gas in 1844; Morton, ether, in 1846, and Simpson, chloroform in 1847. It seems singular that the three anesthetics, now in common use, should have been used first within three years. It would be interesting to trace the history of anesthesia, but the scope of this paper does not permit.

Freezing mixtures have been used for years with success in a limited number of cases, but the tendency to produce death of healthy tissue, makes it undesirable.

The use of cocain, eucaine, stovaine and novocain, with adrenalin chloride solution by the infiltration method has been, generally, used by the profession in minor operations, but it's use in major operations belong to recent years. James F. Mitchell, Washington, D. C., has had the patience to use local anesthesia by infiltration in major operations, previously considered impossi-

\* Read before the February meeting of the Chaves County Medical Association.

ble without general narcosis. He says the reason more local anesthesia is not used in operations is not the fault of local anesthesia, but to American hurry, in part, but more probably to inexperience with the method and a deep-rooted fear of cocaine poisoning, traceable to the days of strong cocaine solutions. Doctors Crile, Mitchell, Bodine and Metas are using local anesthesia extensively. Bodine reports its use in operations for typhoid perforations, in interval operations on the appendix, amputations, herniotomies and operations about the scrotum. Mitchell's observation that the visceral peritoneum is not sensitive unless undue force is exerted on the supports, makes anesthesia unnecessary in vesical surgery after the abdomen is opened. Of course, without the confidence of the patient, the method fails; therefore its use in children and "nervous" individuals is contraindicated. That local anesthesia has a broader field of usefulness than we have in the past thought, goes without saying.

Spinal anesthesia has a field of usefulness. Its use in operation about the rectum and prostate where co-operation of the patient is desired at stages of the operation, is very desirable. In the hands of the profession generally, however, it has not proven safer than general narcosis.

Scopolamine-morphine anesthesia came forth with great promise, but the report of several deaths from its use has relegated it to medical history. It seldom produced complete anesthesia without dangerous symptoms. Ries, of Chicago has used it rather extensively, but has practically discarded it as unsatisfactory and dangerous. Ethyl chloride (and recently Ethyl bromide) has been used for short anesthesia. Recently it has been used more extensively for surgical procedures in the large

receiving wards of Philadelphia general hospitals. It is convenient as it acts quickly and does not require the same preparation as ether or chloroform. Most observers have placed it, in regard to danger, between ether and chloroform. Recently, favorable reports have been made on its use by open methods on Esmarch's inhaler.

Nitrous oxide gas has been used many years by dentists with very gratifying results. The surgeon has been very slow to use it. Bevan made some comments on nitrous oxide gas anesthesia in general surgery in the 1907 session of the American Medical Association, and predicted its more extensive use as a prolonged anesthetic in surgery. Since that time he has used it in operations of the first magnitude. The cost (which is about three dollars per hour for nitrous oxide, gas and air) and the cumbersome apparatus necessary for its use, have done much to minimize its use. At first it was thought to produce anesthesia by asphyxiation, but even Bevan and others have proven beyond a doubt that it is a true anesthetic even in the presence of oxygen in amount equal to that in atmospheric air. The old closed method of giving gas without air or oxygen was only applicable to a very limited number of short operations.

It proved safe but unsuited to operative procedure because of the muscular contracture which was not so much the anesthetic as the method which produced asphyxiation and this, in turn produced the contracture. When improved apparatus was introduced to admit air with the gas, there was some improvement noted, but the disagreeable symptoms were not entirely eliminated. Dr. Ream of Chicago has reported a number of operations under gas-oxygen anesthesia with gratifying results where ether or chloroform



seemed unsafe. The anesthesia was perfect and devoid of after effects. There has not been a death reported from gas-oxygen anesthesia, although it has been used in cases where other anesthetics seemed unsafe. There is no definite quantity of oxygen to be used in general, but patients require varying amounts—from 5 to 15 per cent. In most cases there was no cyanosis or muscular rigidity when oxygen was used in place of air. Bevan says, "It (nitrous oxide) is the anesthetic of choice in reducing fractures and dislocations, in opening abscesses and felons, in breaking up adhesions in joints, in draining empyemas and abscesses of the lung, in exploratory laparotomies, in gall bladder work, removing stones and drainage in kidney work, nephrotomy, nephrectomy and of reprothotomy; in bladder work, suprapubic prostatectomy; in draining appendical abscesses, in colostomy, perforating gastric and duodenal ulcers; in hernia operations, especially for relief of strangulated hernia; in varicocele and open operations for hydrocele; in castration; in amputations, except in larger joints and in removing tumors such as fatty tumors." This statement refers to the use of gas with air but with gas and oxygen there are many more operations which might be added. The cost is a feature (about six dollars per hour for gas and oxygen) but should not be prohibitive at least when other anesthetics are contraindicated. The somewhat cumbersome apparatus is an objection to its general use, but not sufficient to condemn it. It requires some skill to administer it but this is true of other general anesthetics if they are properly given. In view of the known danger of both ether and chloroform in certain cases—kidney and bronchial irritation, myocarditis and in very

young or very old subjects—at least in this class of cases it is a valuable addition to our past methods.

*Ether and Chloroform:* The numerous studies of individuals and the investigation of anesthetic commissions appointed by the British Medical Association and the American Medical Association, have given us some additional knowledge of the danger and contraindications of chloroform and ether, but the surgeons who have been accustomed to using chloroform and ether continue to use the one or the other with little regard for the view of others. It seems that the old adage applies that "A man convinced against his will is of the same opinion still." Ether has been used in general surgery in America more frequently than chloroform, while in Europe the order has been reversed. The advocates of each are sure of their ground; perhaps the explanation is contained in the statement of Allen—"the danger is not so much in the anesthetic itself as in its unskilled administration."

There has gone out a general lament from many men of experience in the last few months in regard to the reckless use of such potent drugs for evil as chloroform and ether. Dr. Roberts of Philadelphia has called it a peril of the hospitals of the country. While they may represent extreme views, yet they contain enough truth to call our attention to the common fault of viewing anesthesia with light regard.

The preparation of a patient for general anesthesia is familiar to all present. I am not so sure that it is not at times neglected.

The anesthetist's table should be supplied with all articles necessary for inducing anesthesia and such articles as may at any time be needed in the resuscitation of the patient, in case of an emergency. It should be under-

stood that such may occur in the hands of the most skillful. The time lost in getting the necessary articles for resuscitation may result in the patient's death.

The room in which an anesthetic is started should be properly ventilated, light and free from noise. The habit of producing anesthesia on the ordinary bed is to be strongly condemned. There should be no one talking but the anesthetist. He can by suggestion encourage the patient, thereby avoiding at least some of the excitement and resistance so often seen.

The preliminary induction of anesthesia by gas and oxygen eliminates not only the unpleasant feature of the beginning of ether anesthesia, but recent reports would seem to indicate that it was much less dangerous.

At the beginning of ether narcosis, the patient should be instructed to blow the fumes away or to breathe deep. The mask should be applied to the face and held in place to let the patient become accustomed to breathing through it, then the ether should be given drop by drop, steadily decreasing the times between drops and moving the dropper continually so that each drop strikes a different place on the inhaler, thereby allowing a better mixture with the air. After the anesthetic has been well started it is a good plan to place a piece of gauze around the inhaler so that the air cannot enter from the side of the mask, in that event it will not contain sufficient ether to produce anesthesia in a reasonable length of time. If at any time the patient refuses to breathe, the mask should be removed for a brief interval, as this is usually caused by administration of concentrated fumes of ether. Should the patient show signs of vomiting the anesthetic should be pushed to destroy the reflex.

The advent of surgical anesthesia is announced by stertorous breathing, loss of muscular tone (the muscles of the eyelid serve) a narrow immovable pupil and a regular pulse wave.

Should the pupil become dilated and immovable, it denotes a dangerous narcosis; a wide movable pupil tells us that the patient is not under the anesthetic. The habit of touching the conjunctiva with the finger nail or other objects is unnecessary and capable of doing harm.

The anesthetist has no time for anything but the anesthetic and his patient. It is not an easy matter to carry a patient along under ether so that the surgeon can give his whole attention to the operation and not produce a dangerously deep narcosis; unless every moment the anesthetist has his mind and eye on the patient. It is comparatively easy to produce profound anesthesia and then watch the surgeon and perhaps allow the patient to become rigid and stop the operator.

After the anesthesia is induced, it requires a small amount of ether to maintain complete relaxation, if the patient receives it drop by drop. The pulse and respiration should be carefully watched as well as the color of the face (pallor of the face always denotes a deep and dangerous narcosis) and the pupil may be examined as often as desired. If a dose of morphine and atropine has been given the pupillary findings will be somewhat uncertain.

Chloroform anesthesia needs description only in so far as it differs from ether narcosis. The same inhaler, with a thinner covering of gauze, and the same dropper as used with ether may be used by regulating it so that it drops more slowly. In giving chloroform the patient should not be told to breathe deep or blow the chloroform away,

as the deep inspiration that follows may carry sufficient chloroform to produce sudden collapse.

Chloroform is the slowest of elimination and should, therefore, be given with the most care only in sufficient quantity to produce anesthesia and no more.

The patient should be kept wrapped in a blanket during and after an anesthetic. After putting the patient to bed, the room should be kept quiet and darkened. A trained attendant should be with the patient constantly. From a pint to a quart of normal saline solution should be given slowly (with low pressure and requires at least 40 minutes to administer) by rectum. This treatment as a routine practice will prevent many of the unpleasant symptoms, such as thirst, shock and nausea.

#### CONCLUSIONS

1. No one anesthetic is applicable to all surgical procedures.
2. Nitrous oxide, without oxygen, should not be used in cases of arterosclerosis.
3. Chloroform is contra-indicated in all cases of weak heart from any cause.
4. Ether should not be used in cases where any kidney irritation exists. It is contraindicated in the very old or the very young. Being inflammable it cannot be used where the actual cautery is to be applied.
5. Chloroform is given too often when less dangerous drugs can be used.
6. The open drop method is the simplest and the safest method of using chloroform or ether.
7. The anesthetist should be trained for his work and know the responsibility of his position. He should be paid and respected accordingly.
8. The responsibility of death from anesthetic should be charged to the anesthetist and not to the surgeon as has been the case in the past.

#### MEMORIAL.

Dr. William Hungerford Burr, of Gallup, died at the Santa Fe Hospital, Albuquerque, April 13th, of pneumonia. He was the son of Dr. Horace Burr, a well known practitioner of Connecticut, and was born at Westbrook, Conn., December 17, 1849. At the age of eight he moved to Wilmington, Del., where he received his early education. After receiving his degree from the Medical Department of the University of Maryland in 1884, he located at Wilmington, but on account of ill health was forced to abandon the practice of his profession for the succeeding ten years.

In 1904 he came to New Mexico and was located at San Marcial for a few months. While at San Marcial he was married to Miss Edith Geer of Connecticut, who survives him.

Leaving San Marcial he took a Post Graduate course at the New York Polyclinic and upon returning to New Mexico located at Albuquerque. Shortly afterward he received the appointment as surgeon for the Santa Fe railroad at Gallup, whither he moved and made his home up to the time of his death.

Dr. Burr's genial disposition, sincerity of purpose and faithful discharge of his duties made his many friends value him both as a citizen and as a physician. He was a very active worker in both his County and Territorial Societies and will be greatly missed.

He was a member of the Bernalillo County and the New Mexico Medical Societies and the American Medical Association.

#### NEWS ITEMS.

Work will be commenced in a few days on the new buildings contemplated.



ed by the Indian department for use as a general hospital or sanatorium for consumptives among the Laguna Indians. This dread disease has been on the increase among the Indians in late years, and the government is about to take steps to eradicate it. It is proposed to erect suitable buildings, with all the latest sanitary arrangements and appliances. Those suffering with the disease will live in the house, and will have the care of efficient nurses and doctors.

Dr. Wm. F. Waugh, 1424 Ravenswood Park, Chicago, is collecting material for a paper on Atropine as a Hemostatic, and would thank any of our readers who would send him notes of their experience with this remedy. He is particularly anxious to receive adverse reports as well as those favoring the remedy.

Those of our members who wish a copy of the first regular edition of "New and Non-Official Remedies," with full description of articles having been accepted by the Council on Chemistry and Pharmacy of the A. M. A., may have same by addressing the American Medical Association, and enclosing 25 cents.

We are in receipt of Vol I No. 1 of PROPHYLAXIS, a monthly Journal devoted to the care of the body and its normal functions, published at Kansas City by the Burton Publishing Co.

This volume contains six splendid papers, among which is found, "The Prophylactic Aspect of the Medical Profession, by Harvey W. Wiley, M. D., of Washington, D. C. The scope and purpose of this publication certainly meets with the approval of all and we wish its publishers every success.

## BOOK REVIEWS.

A Handbook of Suggestive Therapeutics, Applied Hypnotism, Psychic Science—by Henry S. Munro, M. D., Americus, Georgia. Second Edition, C. V. Mosby Medical Book and Publishing Co., St. Louis, 1908. Price, \$3.00.

This is a neat volume of some 350 pages, and is well written, heavy faced type, being used to emphasize every important point throughout the work.

The author's aim is to bring hypnotism and suggestion before the physician in such a manner that he may use them in his every day work for the therapeutic value they may possess. The book is particularly interesting and one who reads it cannot refrain from using some of the suggestions in their practice.

## GONORRHOEA IN WOMEN.

By Palmer Findley, M. D.

Professor of Gynaecology in the College of Medicine of the University of Nebraska. Gynaecologist to the Clarkson Memorial Hospital and the Wise Memorial Hospital, Fellow of the American Gynaecological Society. C. V. Mosby Medical Book and Publishing Co., St. Louis, 1908. Price \$2.00.

This is a monograph consisting of 112 pages with index. An historical sketch is first given after which the author takes up the etiology, pathogenesis, pathology, course of gonorrhoeal infection, diagnosis, frequency of gonorrhoea in women, sociology, treatment, systemic gonorrhoeal infection and adds a complete bibliography. Every physician should realize the importance of anything new on the subject of gonorrhoea in women. This volume certainly awakens an interest which may be lagging and vividly points out the far-reaching effects of a disease which the physician so frequently encounters.

A most commendable work for every library.

## BOOKS RECEIVED.

Transactions of the Medical Association of the State of Alabama for the years 1907 and 1908.

New and Non-Official Remedies, published by the A. M. A., and containing a list of the articles approved by the Council on Pharmacy and Chemistry, up to January 1, 1909.

Reprint—On some Modern Methods for the Clinical Examination of Urine and Gastric Juice. C. F. R. Weiss, M. A., Ph. D., F. C. S., M. P. S., London

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# THE JOURNAL

OF THE

NEW MEXICO MEDICAL SOCIETY

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## CONTENTS

Editorial .....	3
Clinical Report of Five Cases of Milk Sickness, Geo. K. Angle, M. D.....	4
New Mexico Railway Surgeon's Association.....	7
Alcoholism—Acute and Chronic, Dr. W. W. McCormick.....	8
Surgical Empyema, Dr. D. H. Carns.....	12
The Meddlesome Doctor, Dr. John H. Bradshaw.....	14
"Mr. Dooley" on Psychotherapeuticks.....	16
Trachoma, Dr. Frank H. Tull.....	18
The Sterilization of Criminals, Etc., W. T. Belfield, M. D.....	21
Report of a Case of Traumatic Epilepsy, Etc., Dr. M. K. Wylder.....	26

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**EDITORIAL**

There are 374 physicians in the Territory of New Mexico, 290 of which are regulars. Let us endeavor to enroll every one of those 290 before the meeting at Roswell. Your secretary cannot do it alone.

Another County Medical Society has been added to our membership. May 1st, the Colfax County Medical Society was organized and has already assumed proportions which count for strength in our Territorial Society. The following officers were elected to serve for the

first year: Dr. Thomas B. Lyon, Raton, President; Dr. Charles E. Gayer, Raton, Secretary-Treasurer. We desire to extend to the new society our best wishes for a long and prosperous career.

Upon another page will be found a true copy of the last Medical Act passed by the Legislature. Compared with the former Act there are a number of changes to be noted, among which is the striking out of certain word in Section I, which deprives the New Mexico Medical Society of the pleasure of submitting a list of physicians from which the Governor was to appoint a Board of Health and Medical Examiners.

There will be something doing at the next meeting of the New Mexico Medical Society, Roswell, September 15-16. Remember the date.

This will be the first meeting of the Society ever held in the southeastern part of the Territory, and the men in that section have promised all kinds of entertainment for the visitors.

The scientific program is fast being completed and will cover a great variety of interesting subjects.

We have every reason to believe that the coming meeting will be the most successful ever held, besides being the best attended.

An arrangement committee appointed by the Chaves County Society is at work, and will endeavor to surpass anything yet offered in the way of surprises. Mark the date and count on being there. It will be too good to miss.

Roswell, September 15-16.



**CLINICAL REPORT OF FIVE CASES OF  
MILK SICKNESS.**

By George K. Angle, M. D.

In the summer and fall of 1906 a few peculiar cases of a continued type of fever occurred in this vicinity which so far differed from the usual type of disease that the profession were not at all satisfied as to the exact nature of this new fever and it began to be designated by the terms, Mountain Fever, Typhoid Fever, Modified Typhoid, Goat Fever, and one of the profession suggested the possibility of the so-called Malta Fever, which might have been brought over from the Mediterranean by the importation of the Angora Goat. It is significant that all of the cases were intimately associated with the Angora Goat industry. There was at this time, and in fact is now, a disease among the Angora Goats which is described in the herder's language as follows:

"The goat does not want to go out with the flock in the morning and it has to be urged, it falls to the rear in the herd, is stupid, won't eat and after a time falls down behind and drags its hind legs, acts like it was drunk and when any attempt is made to lift it, after it has fallen it cries out with pain which seems to be located in the lumbar spine, the stomach is swollen, the lower spinal vertebrae may necros and ulcerate. The bad cases usually die."

The clinical history of these cases of fever in man, and apparently analogous to that of the goat, is a slow process of infection. Two weeks period of loss of appetite, a gradual loss of strength, sleep is restless and disturbed and during the night they have a fever which is gone in the morning only to re-appear the following night. After the first week the loss of strength forces the patient to bed and the fever now is continuous day and night, with the

usual high point late in the afternoon; the tongue will be heavily furred and the breath has a peculiar odor. They will tell you that they can taste and smell goat. The fever at the end of the first week may come down to normal and continue so for a few days, then go on the same as before continuously, but not of a high range, for ten days or two weeks and then drop as before and then come on again, and this condition continue anywhere from three to six weeks. There is obstinate constipation all this time with a singular tendency to wakefulness and delirium even though the temperature range may be low. I have not been able to detect an enlarged spleen in any of these cases nor any rose colored spots. There has not been at any time the least tendency to diarrhoea but rather a lack of such response to any stimulant to the bowel as to suggest a sort of peristaltic paralysis. The closing history of these cases is that of extreme muscular weakness of the lower extremities and constant pain over the lumbar spine and sacrum accompanied by priapism and neuralgic pains radiating over the anterior lower quadrant of the abdomen, the anterior thighs and along the course of the sciatic nerve.

The following is the clinical history of a case occurring in my practice and which was probably the most severe of all the cases in this county:

W. P. S., age 47; occupation, goat-man; duties, herding, branding and shearing of goats; prior history, negative; eating largely of goat flesh. On or about the 7th of June, 1906, following immediately after the shearing season he suffered with malaise, anorexia, and gradual loss of strength; on June 14, he took a chill, followed by fever, went to bed at his ranch and on June 21 was brought to the hospital at Silver City where he was seen by the late Dr.

Lane and myself. Diagnosis of typhoid fever made and the usual treatment instituted. The case at no time ran a temperature over 102 though there was marked tendency to delirium and restlessness, violent constipation only relieved by copious enemata, no tympanites, no rose colored spots, no gurgling in the illiac fossa, in fact, such a complete absence of everything pointing to typhoid that I remarked to Dr. Lane my doubts as to the diagnosis. I received the usual reply that out here in the mountains at 6,000 feet elevation I was not to expect typhoid fever to resemble that which I may have been accustomed to see back in Pennsylvania. However, since then I have had a number of typical cases of typhoid fever as well as of the other common diseases and do not subscribe to the theory that diseases in New Mexico are changed or modified one iota from that of the states east. I regret that the chart kept in the hospital June 21 to September 1 has been destroyed. However, I can definitely recall the salient points, irregular fever of 99<sup>1</sup> to 102<sup>+</sup> maximum, afternoon temperature irregularly sandwiched in at periods of one week or less by a complete drop to normal lasting a day or two, followed again by the usual temperature range. On September 1st after a quiescent period of two weeks owing to the desire to save expenses he took a room in town and reported once or twice at the office. Temperature was not taken. His convalescence was tedious, his strength did not return, complaining especially of weakness in his legs. Tongue did not clean and digestion remained feeble. On September 24 I was called to his house, found him in bed, face flushed, eyes injected, pulse rapid, showing fever, a well-defined tumor in the umbilical region of the abdomen which proved to be fecal impaction. On Sep-

tember 27 I again returned him to the hospital as he was now unable to get out of bed, being totally disabled by a weakness, but not a paralysis of his legs, though the strength in his arms and hands was normal and there was little loss of the subcutaneous adipose. The temperature record in the hospital dating from September 27 was as follows; giving maximum and minimum daily temperature:

Sept.	27	6:30 p. m.	99 <sup>3</sup>	
"	28	Normal		
"	29		97	and 100 <sup>2</sup>
"	30		100 <sup>2</sup>	102 <sup>2</sup>
Oct.	1		99 <sup>2</sup>	100 <sup>2</sup>
"	2		98	99 <sup>3</sup>
"	3	Normal.		
"	4	Normal.		
"	5		97 <sup>2</sup>	99
"	6		97	99
"	7		97	99 <sup>1</sup>
"	8, 9, 10, 11, 12, 13 and 14	Normal.		
"	15		97 <sup>2</sup>	101
"	16		97	101
"	17		98	101
"	18		98	101 <sup>2</sup>
"	19		99 <sup>2</sup>	100
"	20		100	102 <sup>1</sup>
"	21		99 <sup>2</sup>	100
"	22 to 26 inclusive,	Normal.		
"	27		97	99
"	28 to 30,	Normal.		
"	31		98 <sup>3</sup>	100 <sup>1</sup>
Nov.	1		99	101 <sup>4</sup>
"	2		98 <sup>4</sup>	99 <sup>2</sup>
"	3 and 4,	Normal.		
"	5		99 10:15 a. m.	103 <sup>4</sup>
			(Meningitis?)	
"	6		98	100 <sup>1</sup>
"	7	Normal.		

On November 5th I was called hurriedly, found patient with eyes injected, delirious, oposthotonos, terrific pain and tenderness over whole length of spine, but especially in the lumbar region, the spasm of the spinal muscles was so severe that his head was deeply buried in the pillow and his back lifted from the bed. This condition of acute irritation and congestion of the spinal meningitis passed away in 36 hours and from this time until December 8th temperature remained normal, but the pain in his back and the weakness in the legs continued and patient was unable to

turn over or get out of bed, strength in arms normal, no marked loss of subcutaneous adipose. On December 8th he was removed to the house of a friend where he continued in practically the same condition three months, then gradually gained strength enough so that he was able to go about on crutches and in April, 1907, he was strong enough to again ride a horse and return to work though still partially disabled. I did not see him again until July 1, 1908, when he dropped into my office to pay a friendly visit. He tells me that even now after more than a year he still has trouble to raise to an erect from a leaning position. There is now noticeable a certain atrophy of the lower spinal muscles and the skin of the lumbar spine and sacrum still shows the stain of the former echymosis.

The second case of mine was that of an aged Mexican, whose clinical history was practically that of the case reported. In this case no reports were kept and patient visited only a few times by myself, when he sought treatment in Old Mexico but without results. He was practically disabled and unable to do any work for the period of one year.

The third case of mine was also a Mexican goat herder and the history about the same as the one reported. His disablement was of eight months duration to my knowledge when he left the hospital on crutches and has not been heard of since.

The two other cases, both natives of the United States and engaged in the goat industry, occurred in the practice of Dr. F. P. Whitehill, with a clinical history analogous to the case I have reported, both having the long, tedious convalescence by reason of the extreme weakness of the lower extremities always accompanied by a neuritis of the

anterior crural and sciatic nerves. Their disablements lasted a period of seven months.

In the case of W. J. S., which gave me an opportunity to see frequently and observe carefully after the first period of three months had passed. I am of the opinion that the nature of this case after September 25th was that of an acute congestion and inflammation of the lumbar portion of the spinal cord, more or less constant priapism, pain, and oposthotnos as before mentioned seems to me to be so significant as to be explained in no other way. The fact that such a number of these cases were all associated closely with goats and especially occurring at the time immediately after shearing season when the men were in direct contact with the goats, inhaling the dust from the pen and eating goat flesh would indicate the entrance into the system of some specific poison acquired from the goat. The fact that this disease uniformly left all its victims with a semi-paralysis of the lower extremities, and the same condition being present in the goats themselves even to a greater degree, would argue for one and the same disease. The constant and obstinate constipation in all cases, the temperature falling to normal so often in the course of the fastigium, the fact that the subcutaneous adipose was so well preserved in all cases argues against a typhoid fever. After having thought over all that might make for typhoid and all that was against it I have not been able to make myself believe any of these cases were enteric in their nature. In the absence of a better diagnosis I shall call them milk sickness, a disease about which but little is known.

In November, 1907, Drs. Jordan and Harris of the University of Chicago visited the Pecos Valley at the request



of Drs. Doepp and Friedman of Carlsbad to investigate an epidemic of this sort. They saw quite a large number of cases and made a partial report in the Journal of the American Medical Association of May 23, 1908. The organs showing the most conspicuous pathological condition were the liver and kidneys both of which were enlarged and gorged with blood, showing acute parenchymatous degeneration and some fatty metapohosis. The intestines were much injected, the spleen normal. In only one case, unfortunately, was the brain examined, owing to the lack of proper tools. This case showed congestion of the meninges and the ventricles were filled with excess of fluid. Cultures were made from the blood and a long, slender bacillus discovered which they have designated the bacillus lactimorbi. The virulence of the poison was shown by the fact that 2cc of heart blood from a dead animal injected into a rabbit was followed by fatal results.

In my experience the treatment of this disease is purely symptomatic. In the latter period after the more acute condition had passed, electricity, massage, counterirritation, and hot baths all were used but without results. With our present knowledge preventive medicine offers the only hope. In the face of an epidemic of this kind no flesh or milk belonging to a herd known to have any sickness of this kind should be used, all diseased animals should at once be isolated and if severely sick at once killed and carcasses burned. Those engaged among goats and cattle should keep the upper air passages clean and disinfect their hands before meals and at bed time, using every means of precaution.

In conclusion let me say I regret that I cannot submit a more scientific paper but the general practitioner dealing only

with the clinical phase of disease can offer only a clinical report. The pathologist and bacteriologist must work out the scientific side of it. I hope this paper may stimulate a peculiar interest among the profession and that wise counsel may save many a poor unfortunate from a sickness of months' duration, a year's loss of time and perhaps in some cases the savings of years of hard work and self-denial.

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#### NEW MEXICO RAILWAY SURGEONS' ASSOCIATION.

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At the last meeting of the New Mexico Medical Association the railway surgeons present took occasion to organize The New Mexico Railway Surgeons' Association. This new society of physicians and surgeons starts off under most favorable auspices, with a list of fifteen charter members.

All regularly appointed railway surgeons residing in the territory of New Mexico are eligible to membership.

The object of the society shall be the closer association of the railway surgeons of the Territory of New Mexico for their mutual protection and benefit.

The time and place of meeting will be the same as the New Mexico Medical Society.

The officers for the ensuing year are, President, Dr. J. A. Massie, Chief Surgeon Santa Fe Central Railway, Santa Fe; Vice-President, Dr. W. H. Goelitz, Las Vegas, N. M.; Secretary and Treasurer, Dr. S. D. Swope, Deming, N. M.

The dues were fixed at one dollar per year with no initiation fee.

It is to be hoped that every railroad surgeon in the Territory will join the organization and this young and husky addition to the medical fraternity will prove a power for good in the land.

## ALCOHOLISM—ACUTE AND CHRONIC.\*

By Dr. W. W. McCormick.

The subject assigned to me is one about which so little has been said that you doubtless expect little more than extracts. In this you will not be disappointed. However, you are asked to indulge in much criticism, when the writer boldly disagrees with eminent authorities in an effort to place squarely before you, Chronic Alcoholism without sequelae.

We find, only, Acute and Chronic Alcoholism in our text-books. The first, characterized by morbid results of excessive or prolonged use of Alcoholic liquors; this term has been used as a synonym for many other names—and Chronic Alcoholism, to be associated with severe lesions or disturbances of any and all parts of the human economy. All forms of alcoholism in its protean manifestations have for their cause a real and substantial basis.

The history of Alcohol will not be discussed because its advent was before my time.

Alcohol presents so many complex questions that it is necessary to consider briefly their nature and etiology before attempting to discuss the diagnosis, prognosis or treatment.

Strictly speaking, Alcoholism may be only a symptom but we will here consider it a disease,—either hereditary, congenital, acquired, chronic or acute. The writer well knows the antagonism this arrangement of disease, which is foreign to all text-books, may meet at your hands, and offers no apology in characterizing Hereditary and Congenital Alcoholism as always Chronic and Acute attacks of chronic alcoholism a misnomer or unscientific, to say the least.

*Heredity* in disease is, according to Gould, transmitted from parent to offspring.

Darwin's theory—suppose that each of the different cells of the body gives off gemmules or germ particles, that are capable of reproducing their kind and which are included in and constitute the generative cells and thus reproduce all of the peculiarities of the original organism. In Vol. VI, page 279 of the Reference Handbook of The Medical Sciences, we find that the sexual cells may be affected by the intoxication of either parent.

The new-born of Chronic Alcoholists very frequently show malformations and later, physical disturbances. This is particularly the case in maternal Alcoholism during pregnancy.

*Congenital.* Existing at birth—Maternal Impression.

The influence of impressions received by the mother during gestation has always been regarded by the laity, and indeed by not a few members of the medical profession as well, as a most potent cause of malformations, nor is it strange that this venerable and deep rooted fact should continue to be regarded with favor. It must be admitted that an unusual impression on the mind of a pregnant woman is capable of producing defects in the foetus closely resembling the object responsible for the impression. There are sufficient grounds for believing that the mental state of the mother may, indirectly influence the development of the offspring by inducing congenital changes in nutrition, the writer having had the sad experience in his own family.

Appreciating the honest convictions of many, in the belief of the power of such impressions and the convincing testimony adduced in support of such

\* Read before the Bernalillo County Medical Society, May 5, 1909.

views, it must be borne in mind that, the teachings, so far, of embryology are opposed to such claims.

*Acquired Alcoholism.* — May be either acute or chronic—acute when for any reason one goes on a spree or drunk at rare and uneven intervals as a result of social privileges or celebrations—and Chronic Alcoholism, when, as the word indicates, the disease is of long duration—slow progress.

Acute Alcoholism, as above stated, the word acute, is used in disease, of having a rapid and severe onset, progress and termination. It is evident, then, that acute alcoholism is never chronic nor has the writer been able to find classified, acute chronic disease. In chronic acquired, congenital and hereditary alcoholism, we may have increased or paroxysmal violence of the symptoms of the disease—exacerbation—but never acute.

Location, environment and climate all play their important part. Less whiskey is consumed in the north than in the southern climates as evidenced by the writer's experience in the British Yukon territory where U. S. P. Compound Cathartic pills sold for \$2.50 per dozen and whiskey at fifty cents per pint. In coming south the price of compound cathartics steadily decreased and that of whiskey arose until at the extreme southern boundary of the United States the purchasing value of a pint of whiskey was fully six dozen compound cathartic pills.

It is a significant fact also that few colonels in the north live to enjoy their title.

Pathology of this trouble can not be more distinctly given than that which covers the realm of human knowledge.

Symptoms of both acute and chronic alcoholism are so well known that further discussion at this time is deemed unnecessary.

*Sequelae.*—Let us understand that Gould says this is "any disease or abnormal condition that follows an attack of disease or an injury." We, therefore, know that the entire human economy in all its sizes, ages and conditions, is the only limit to the sequelae of these conditions and time would not permit even a mere reference to some of the more important nor is it necessary for we have alcoholic this and alcoholic that until it is no wonder that the terms are familiar, that they are preserved, being constantly in alcohol.

Diagnosis of chronic alcoholism, usually, is not difficult. The clinical picture of the disease together with the history and surroundings can scarcely admit of being confounded with any other. However, in alcoholic coma either from acute alcoholism or exacerbations from chronic acquired, congenital or hereditary alcoholism, we find the picture very different, so much so that fortunate is the man who can make a positive diagnosis.

Alcoholic Coma may easily be confounded with that of Apoplexy, Opium Narcosis, Concussion of the brain, acute pneumonia, uremia and epilepsy. The differential diagnosis being almost impossible to make with accuracy when the coma is deep. The pupils afford no trustworthy indication as they may be either dilated or contracted in alcoholism. They are often unequally contracted in apoplexy, and in apoplexy of the pons Varolii they may be equally and minutely contracted, as in opium poisoning.

The difficulty of diagnosis is increased by the common practice of giving whiskey as a reviver so that a stranger found insensible on the street may smell of alcohol without having been the subject of alcoholism.

When no accurate history of the case can be obtained the diagnosis is simply



impossible. Delirium Tremens with which we are all more or less acquainted, is really only an incident in the history of chronic alcoholism.

Your attention should especially be called to Alcoholic Neuritis, as its appearance may be the first revelation to the physician or to the family of secret drinking.

It occurs most frequently in women, particularly in steady, quiet tipplers this is of the utmost importance from a diagnostic point and you are referred to authorities for further enlightenment upon this sequelae.

Prognosis.—Before a plan of treatment is instituted, we are invariably asked to give a prognosis, and into this, as has already been shown, various elements enter.

So far as Alcoholism is concerned in any and all of its forms, the prognosis is most favorable—not so, however, with the sequelae and relapse is most frequently due to the latter.

*Treatment.*—Acute Alcoholism rarely needs treatment of any kind unless it is to sober him up for business or social functions, evacuate the stomach, sedatives, baths, etc., are within the reach and knowledge of all of us. In chronic alcoholism, either acquired, congenital or hereditary, the sequelae mentioned almost always a serious neuropathic element is so evident that one is surprised to find how little they are taken into account in the various special methods of treatment in vogue. No real attention is paid to the underlying nervous disorder itself, the importance of taking this factor into account and the success so frequently attendant upon such a plan is well worth your careful consideration. Having carefully studied our patient the first problem that presents itself is the withdrawal of the liquor. While opinions differ, this can be done without diffi-

culty by the patient himself in from 6 to 48 hours with safety by the use of the following:

Yellow oxide of mercury  $\frac{1}{8}$  gr.  
Fluid extract of coco and Buchu 16 Minims and of Gentian 8 Minims every two hours in water and hypodermic injection every four hours of Mercury Bichloride—Atropia and Morphine Sulphate. Whiskey becomes repellant as regards both sight and odor and its taste becomes intolerable, producing nausea.

We are told to be guided largely by the action of the heart, collapse, mental confusion, delirium and excessive prostration, but with the above treatment the writer's attention has never, in fifteen years' experience with alcoholism, been called to these conditions outside of the text-books.

It may be well to state that, here for pathological reasons, Apomorphine should never be given—remember this—drugs and their employment depend upon each individual case. No routine method of their application, no one drug, no one formula, can be considered as applicable to every case. The use of a given drug depends entirely upon the symptoms present and varies with each case. It is of course, evident that the writer favors the treatment above mentioned to begin with, results justifying their employment, yet the technique must be considered.

The writer hopes at some future time to give in detail his full and complete treatment for alcoholism with technique and report on more than 4,000 cases treated by this method.

Having discontinued the use of alcohol the physician should exert every effort for the study of the morbid conditions underlying the disease and for their proper treatment—get at the pathological condition—treat the sequelae when, it is the writer's belief, the

Emmanuel movement may accomplish something with the alcoholic which, it is said, already, is very gratifying.

Many of the poorer alcoholics not only are given psycho-therapeutic treatment, but the social service worker inquires into their surroundings, conditions, temptations and attempts to remove or remedy them. Every physician from the beginning of time has made more or less use of psychotherapeutic methods by bringing to the sick-room a hopeful personality, cheerfulness and encouragement to the patient. Nothing but the deepest respect and confidence in the outcome for this treatment can be had by medical men. It is from medical men that we must expect real advancement and information of what has been and can be done in this direction, but physicians should attend the meetings of these Cults to get acquainted and analyze what they are doing for no benefit can result by associating with people who are wholly unqualified, untrained and unfit for this work.

That we have not sufficiently recognized the importance of psychotherapy has doubtless driven many into the hands of laymen, who are willing and more or less capable, to make use of a method, perfectly legitimate in itself, but on which, the medical profession has frowned. In place of abusing those who are ready to try to do what we ourselves should have done, perhaps long ago, let us make use of the powerful weapon at our command.

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#### ACCURACY IN THERAPEUTICS.

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The efficiency of a medicinal agent cannot be determined by mere physical appearance. Two specimens of

fluid extract of digitalis, for example, may look precisely alike. One, upon administration, may exhibit a wholly satisfactory therapeutic action; the other, given under precisely the same condition, may prove to be practically inert. Lack of uniformity in the crude drug, and absence on the other hand of an adequate method of assay, account for the singular discrepancy. And this serves to show the necessity of standardized remedial agents if we would proceed in the treatment of disease with any assurance of success. It emphasizes, too, the futility of trusting to chance that the extract of a crude drug contains what the practitioner supposes it to contain and what it ought to contain.

It is a healthy sign that manufacturers of medicines—some of them at least—are giving serious thought to this matter of standardization. It is cause for gratulation that the largest producers of medicinal products in the world consider the subject of sufficient importance to make it the basis of an expensive promotion campaign. We have in mind a series of announcements which have been published from time to time in practically the entire medical press of the country, the latest appearing under the significant title, "Who is the Keeper of Your Reputation?" In their plea for greater accuracy in therapeutics Messrs. Parke, Davis & Co. are doing vastly more than to exploit the products of their manufacture—they are rendering a lasting service to medicine.

It is to the physician's own interest, and to the interests of his patients, to prescribe standardized preparations; to provide himself with the most trustworthy agents that the market offers. The best is none too good for his purpose.

## SURGICAL EMPYEMA.\*

By Dr. D. H. Carns.

Mr. President and Members of the Bernalillo County Medical Society:

In presenting a paper upon this subject, which is common in occurrence, and which has been recognized from ancient times, the writer has not found medical literature replete with articles upon it, but rather a scanty touching of the subject. Again, too, the different surgeons, while writing prolifically on other subjects, have been strangely silent upon this one up to a recent date in their articles in the journals and their monographs. The general consensus of opinion in the text-books up to a late date, has been aspiration in children, and rib-resection in adults, but the draft now is towards the treatment as devised by Beck of Chicago, the so-called "Bismuth Paste" treatment. This will be considered under treatment.

Empyema, or suppurative pleuritis, is defined as a collection of pus in the pleural cavity. It is due to an infection of the pleura, and an endeavor should be made in every case to isolate the causative bacteria. The varieties, or classes are: A total empyema where the entire pleural sac is involved. A partial, where it is localized, and the pus encapsuled. A closed empyema is where no opening has occurred spontaneously, nor has one been made by the surgeon. Small empyema are sometimes cured by encapsulation with fibrous tissue and Paget states that a small one due to the pneumococcus occasionally undergoes spontaneous cure, through absorption. After spontaneous rupture, it rarely cures itself, a pleural fistula usually remaining. Pneumothorax generally follows rupture into the bronchus.

Empyema pointing externally is called "Empyema Necessitatus." Pointing generally takes place near the sternum, between the lower cartillages.

Double empyema is rare, and a very fatal disease, usually caused by passage from one side to the other through the mediastinum.

Causes: Contusion, or wound, pneumonia, tuberculous pleuritis, tuberculous caries of ribs, subphrenic abscess, suppurating hydatid of liver, influenza, pyogenic infection of a serous effusion, abscess of liver, specific fevers, especially typhoid, malignant disease of the pleura, pneumothorax, and the gonococcus. Bouchard states that it is due when acute, to a special organism.

The bacteria most commonly the causes, are the pneumococcus, the streptococcus, the *bactillus typhosus*, *bacillus tuberculosis*, and the staphylococcus. As the pneumococcus is short lived, it may not be demonstrable in the evacuated pus, although it was the original cause.

Symptoms: Acute—Dullness on percussion, bulging intercostal spaces, dyspnoea, pallor, cough, sweats, chills and usually irregular fever. Sometimes there is oedema of the skin of the chest. Pronounced leucocytosis, and at times clubbed fingers. Empyema of the left side may pulsate. If pneumothorax has taken place there will be in addition a very foul breath.

Chronic—All the symptoms of pleurisy will be present in the case, with greater degree of prostration, and exhaustion. The lung is shrunken and compressed. The pleura very much thickened. Grocco's sign, the paravertebral triangle, will be of value, although it will occur with subphrenic abscess, as well as with pleurisy, and empyema.

Pathology: It is sometimes a primary affection, especially in children. Usually it follows a previous disease of

\* Read before the Bernalillo County Medical Society.



an organ nearby, and comes on slowly and insidiously, more often following in the wake of pneumonia in a convalescent, who at first has an ordinary pleurisy. The most probable causes are tuberculous cavities in the lungs, which have broken down, liver abscess perforating the diaphragm, perforations by ulcerations, or cancerous conditions of the oesophagus, stomach and bronchus, and escape of infecting materials in the pleural cavity. A general septic infection may be the cause, following a wound, with entrance of pyogenic bacteria into the pleural cavity. At times serous, or fibrinous pleurisy may become secondarily suppurative. In children the pneumococcus occurs most frequently, while in adults the streptococcus and tubercle bacillus abound. Netter's table gives the following:

Bacteria.	Children.	Adults.
Pneumococcus .....	53.6	17.3
Pneumococcus and Strept .....	3.6	2.5
Saphrophytic .....	10.7	....
Staphylococcus .....	....	1.2
Tubercle .....	14.3	25.0
Streptococcus .....	17.6	53.0

The aspirated pus has different characteristics, being at times yellow, at other times curdy, or discolored, at times decomposed, and fetid. The pus may be absorbed when the virulence of the infection has been overcome. The pus in closed empyema is rarely putrid, in open empyema, it is usually putrid.

Pneumothrax is the result of erosion through the lung tissue, into the bronchus. The pus may penetrate the costal pleura, and thread its way between the ribs and point externally, usually near the sternum, between the lower cartilages. It may rupture into the stomach, peritoneum or pericardium, and may go so low as to simulate a psoas abscess.

Postmortem, the appearance of the fluid is as after aspiration, that is, it separates into two layers, a clear fluid

above, and a thicker sedimentary layer below. The pleurae are coated with fibrin, and oftentimes show erosions, and ulcers. The contour of the chest is generally altered, after severe empyema.

Treatment.—To a recent date the treatment has been chiefly confined to aspiration in children in the empyema of pneumococcus and to the operations of Schede, Estlander, and Fowler in adults. These are still in general use, and many good results have been obtained. The operations, however, are severe—nature and greater the degree of the operation, the greater the severity, and danger. These operations are found in all the text-books, so that a detailed account need not be given. I purpose to give you the later methods as in use by Dr. Beck, as it was my good fortune to see it demonstrated by him, during my recent trip East. This is the so-called "Bismuth Paste" treatment, applicable for the treatment of empyema, tuberculous sinuses, abscess cavities, and fistulous tracts. This treatment is now in general use by most of the prominent surgeons of the East. The paste is sterilized before use, and the syringe is filled while the paste is hot and liquid. A glass syringe like that of a Valentine irrigating tip is filled and pressed tightly against the opening; the emulsion is forced in slowly until the whole cavity is filled, and the patient complains of pressure. Remove the syringe, and cover the opening with a piece of gauze to prevent the paste escaping. The paste will soon harden, but this may be hastened by an ice-bag over the site of the injection. The injection of course, is made after aspiration. A newer syringe has been devised. It is of metal, with a flexible metal tip so as to stand a greater strain than ordinary rubber will stand.

The injections are made every second day, completely filling the cavity at each injection. Usually three weeks are sufficient to effect a cure, and to obliterate the cavity.

Radiographs are taken from time to time, so that the process of repair may be studied, and the diminution of the cavity may be seen as repair progresses. The bismuth offering great resistance to the rays makes it most valuable in the study of repair. The shadow obtained shows the true picture of the cavity, and its branches. The solid substance acts as a framework for the formation of healthy granulations. Again, as Beck states, it is probable that the bismuth becomes radioactive on exposure to the rays, and promotes the formation of granulations on the walls with which it comes in contact. To increase radioactivity he adds strontium salicylate. After the absorption of the paste the connective tissue remaining contracts, and thus obliterates the cavity. This principle of the network is on the principle of Bartlett's filigree, but with the advantage that it is absorbed. This treatment does away with irrigating such with water solutions which cause maceration of the tissues, and fill up sinuses, and prevent formation of healthy granulations.

There has been some criticism of the treatment in some of the journals, as the authors have not obtained the results as claimed by Dr. Beck, but it is probable that it is the "Scandenberg Sword," that is that Beck has given the treatment, but not the hand that knows how to use it. I have lately seen used a treatment as devised by the Master Surgeon J. B. Murphy, and while it is in its infancy still, yet coming from him is worthy of great consideration.

It is first in the aspiration of the

contained fluids, and the injection of one to five ounces of a two per cent solution of formalin in glycerine through the same canula without removing the instrument, renewing the treatment in ten days to two weeks if necessary. Bryant uses suction, which is a modification of Bulau's syphon, the suction being accomplished by use of collapsible rubber bag.

By this treatment the exudate is evacuated, and negative pressure, assisted by the normal respiratory movement, tends to expand the collapsed lung. The formulae of the Beck pastes are:

#### No. 1.

R. Bismuth subnitr.....	30.00
Vaseline .....	60.00
Mix while boiling.	

#### No. 2.

R. Bismuth subnitr.....	30.00
White Wax	
Soft paraffin aa .....	5.00
Vaseline .....	60.00
Mix while boiling.	

No. 1 used for diagnosis and early treatment; No. 2 used in later treatment. Formalin 1% is added in some cases.

In concluding, it will be well to sum up with Beck's conclusions:

That it is safe, has no unpleasant symptoms, that it forms the net-work for the granulations to form around, that it is absorbed, and the fistula obliterated, and that it intensifies the picture taken, and eliminates the possibility of error as to the size of the cavity, and shows progress towards repair.

#### THE MEDDLESOME DOCTOR.

By John H. Bradshaw, M. D., Orange, N. J.

It has ever been said to the credit of the medical profession that it believes in action. The terms active practitioner, active membership in speaking of societies, active treatment in speaking of disease, have long been terms of

approbation. It is not the purpose of the writer to decry the essential activities without which there would be no progress either in the arts or in the sciences. There are times, however, when action does not denote advancement, but interferes with progress, and, when applied in medicine, may justly be termed meddling, and he who practices it should be termed a meddling doctor. Meddling widwifery has long been a byword of reproach and many practices of the past are justly so called. As the accepted activities of today may become the meddling activities of tomorrow, one cannot be too dogmatic or demand inflexible rules. But there are many things done today that our patients would be better off without—there are procedures performed that are of no benefit to the patient; unnecessary activities that may be even of direct injury to his welfare.

It seems hardly necessary to call attention to the large amount of unnecessary drugging a busy doctor is likely to give an anxious patient. How often we find a patient with a self-limited disease—say with pneumonia—taking the whole gamut of respiratory stimulants, expectorants and heart tonics before there is any real indication, and alcohol and strychnine thrown in for good measure, with oxygen gas to ward off a cyanosis there is some doubt if it really helped. All this activity often disturbed the patient's rest and that important assistant in all diseases—the stomach. In other troubles, too, we often get into the habit of giving medicine—we had done so before and the patient recovered. Why not do so again? Surely it is just as reprehensible to get into the habit of giving unnecessary drugs, even if they be all culled from the pharmacopœia, as it is to get into the habit of prescribing proprietary preparations and nostrums.

The doctor who gets into the habit of giving this or that drug without a clear indication is often a meddling doctor.

The whole subject of healing in surgery is made up of attention to nature's methods of repair. It is here in particular that interference with her ways brings delay if not disaster. Was it strange that our laparotomies that were purged into weakness before the operation—that were vivisected by the hour, wiped and douched, irrigated and packed with iodoform gauze, then again purged the following day and withheld for days from any fluid, should have given a high mortality? We have learned, it is true, to do better work today, but we fed the grim reaper before we learned our lesson.

The first fecal fistula case the writer ever saw was one following an operation for gangrenous appendicitis in 1884. Great care and pains were used in wiping out the fistula daily with a bichloride solution. The fistula ran for weeks and weeks and the patient died from exhaustion. Some years ago when we were trying to quickly heal our simple fistula, following suppurative appendicitis, we used huge quantities of peroxide of hydrogen in foolish attempts to hasten the cure. Next we used to leave our gauzes so that they coked up instead of draining our wounds. Was it any wonder that our patients made slow recoveries? Such efforts were meddling and the doctor a meddling surgeon.

We have learned from the school of experience that the methods of the dissecting table are not the methods of the operating table—that too much refinement in our work is not to our patient's welfare—that it is better to "get in quickly and get out quickly" than it is to attempt to do too much. It is hard for us to learn to leave our wounds



alone. Our wounds heal often not because of our activities, but in spite of them. The healing is often delayed by too much dressing. Why should a granulating wound or fistula have the discharge often and laboriously scoured away? Do we not wish that invisible pellicle of embryonic cicatrix to form? Why should we eat it up by injecting peroxide of hydrogen or roughly wiping it away? In doing this do we not often wipe germs from the surrounding skin into our sterile wound? In the case of our laparotomy wounds, do we not often invite skin suppuration and stitch abscess by too early and frequent dressing or by taking down the dressing "just to see how it looks"—palpating a scar to see if it is all right, or poking a probe—even if it be carefully sterilized—into a recess of our wound to find if there is not a little pus? The same needless activity that squeezes a boil or wounds after pus has formed, must be checked or delay and not progress will be seen. Open wide the vent, when necessary to keep it open and do not obstruct the opening, and nature will do the work. It will surprise us often to see how quickly she will do it.

It was hard for us to learn that the milky peritoneal fluid that we often see in acute cases of appendicitis should not be laboriously wiped away. It was hard for us to learn that the temperature curve is caused by the battle of the leucocytes, who are fighting in our interests. It is hard for us to stand by and just wait. Inactivity, however, to be "masterly" must, in fact, be masterly and intelligent or it will end in neglect.

NOTICE:

Next meeting of the  
New Mexico Medical Society  
at Roswell, September 15, 16.  
Remember the Date!

"MR. DOOLEY" ON PSYCHOTHERAPEUTICS.

Chicago, Oct. 16, 1908.

Mr. Editor: "Have ye read of this new thing they call sycotherapewticks that's privalint in Boston?" asked Mr. Dooley, as he laid aside the daily paper and turned to Mr. Hennessy.

"No. Is it ketchin'?" demanded Hennessy, anxiously.

"Sure it's not a disa-ase at all, at all," replied Mr. Dooley in his most professional manner. "It's a new rimidy."

"Glory be!" exclaimed Mr. Hennessy. "Is it ha-ard ter swally?"

"Faith, it isn't like Father John's midicine or anny iv thim things," went on Mr. Dooley. "It's this way: Boston is a sthate iv moind, an' whin anny wan sickens there it's th' moind that gits attintion. F'r instance, whin little Indicutt begin ter pine away an' th' nose-piece iv his specs has ter be thrimmed with fur ter keep th' metal fr'm pressin' on his poor little brain, an' he spinds his nights huntin' th' snark an' ither man-a-a-tein' game in th' heart iv darkest A-africa with Teddy Rosenfelt, thin he's ripe fer sycotherapewticks."

"It's like casther ile, thin," ventured Mr. Hennessy.

"Ye talk like an omadhaun!" snapped Mr. Dooley, impatiently. "It's naw-thin' iv th' koind. No, they call in th' pasther iv th' church. 'Ah, me little man, it's obssised ye are,' sez he. 'It's a bad case iv th' dissociashun iv th' persona-ality ye have,' sez he, an' be a quick pass iv th' hand he lands little Indicutt inter a sthate iv hipno-osis which is th' thrade name f'r a kind iv near-slape. In this condition the poor little divil is completely at th' good man's mercy, an' th' secret wurrukin' iv his moind is as clear ter th' pasther as th'

spring waters ye see advertised in th' magazines—if ye believe th' adverteisements. In less time than it takes ye ter impty a can iv beer, Hinnessy, th' boy's moind is spiritooly dhry-clinsed iv its obsissions and th' boy comes back ter airth or as near there as they iver get in Boston. 'Lave him take an exthra coorse in thransindintal ferlosofy,' says the good man in partin' fr'm th' overjiyed parents. 'It'll kape his attintion off iv himsilf. But be careful how ye expose him ter th' frish air.'

"It bates the devil what leeps science is makin'!" exclaimed Hennessy, when his powers of speech returned.

"An' they threat th' grown-ups th' silfsame way," went on Mr. Dooley, full of his subject and unmindful of his friend's comment. "Whin wurruk is slac' at th' foundhry and th' father iv th' fam'ly doesn't know where th' price iv the next pot iv baked beans is comin' fr'm, ter say nawthin' iv th' rint an' th' other lux'ries iv life, he begins ter recognize th' simtims iv a refracthry subconshus—such as cowl'd feet, an' an inability ter look th' landlord an' th' bo-otcher straight in th' face—an' drops in ter th' sycotherapewtick clinic fer afthernoon tea and ifther threatmint."

"An' how does that hilp him on th' rint an' th' bo-otcher question?" asked Mr. Hennessy, critically.

"That's simple," replied Mr. Dooley. "He goes away full of tea, angel cake, an' be-yewtiful sintimints that inable him ter rise about his troubles, and whin th' graspin' landlord an' th' bo-otcher with th' Armour-clad hea-art begin ter do sintry duty befor his dhoor in comp'ny with th' ither wolves, th' poor man retires inter th' subcellar iv conshusniss an' puts up th' amnashia shutters, which is a sure protecshun agin painful mimries."

"Wunderful! wonderful!" ejaculated Mr. Hennessy.

"Th' same threatmint applies ter all th' ither human ills," continued Mr. Dooley. "If th' hea-art gets inter a frolocksome mood an' takes ter skippin' beats up an' down th' spine; if th' stummick contrac's th' playful habit of telescopin' itsilf inter th' dhudeenum; if th' rist iv th' organs refuse ter wurruk undher union rhules, it's cycotherapewticks that's needed."

"But what does sycotherapewticks ra-ally mane?" asked Hennessy, with a dazed expression.

"That's what no wan seems ter clearly undherstan'," replied Mr. Dooley. "As near as I can make out, it's a species iv spiritool flim-flam. We are all born in orig'nal sin, Hinnessy, an' th' divil's in iv'y wan iv us. Ye may think ter dhrive him out be baptism, but don't fool yersilf. He's still with ye in as manny dif'rnt forms as ye have fingers an' toes. That's why ye suffer fr'm a mooltiplica-ation iv th' personality. Whin th' ould boy gets inter yer liver, ye're wan feller, an' whin he sthriges yer big toe in th' shape iv th' gout ye're another. Ye know yersilf, Hinnessy, that whin ye go home an' swear at th' ould woman an' caress th' childer with th' wooden ind iv th' broom, yer're not th' same ja-anial spirit ye are whin ye're sthandin' up ter th' bar an' somewan else is orderin'. It's the divil that's at th' bottom iv all our sufferin', an' it takes th' pasther an' his sycotherapewticks ter dhrive him out."

"An' are there no more reg'lar docthers in Boston like ould Doc Sullivan here?" asked Hennessy.

"Very few, I hear," replied Mr. Dooley. "Them as haven't made their forchun be thrimmin' off the appendix are now sellin' fairy stories written by spiritool sycollargists."

"But even sthills I don't clearly undherstan' th' meanin' iv sycotherapewticks," protested Hennessy.

"That's just the *crooks* iv the situa-shun, as they say in argymints. Ye are in the same box as th' pasthers, Hennessy."

"An' ye say that Boston is on'y a sthate iv moind?" queried Mr. Hennessy.

"I do," affirmed Mr. Dooley.

"Thin it must be a nawful bad sthate ter be in," finished Hennessy, sentimentously.

Very throoly yours,

J. W. C.

(With humble apologies to Mr. F. P. Dunne.)—Boston Med. & Surg. Journal.

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### TRACHOMA.

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By Dr. Frank H. Tull, Albuquerque.

The history of Trachoma is a most interesting study and possibly no disease of the eye in regard to which more literature has been pronounced in the course of ages as in regard to this disease. Nevertheless we are still far from a clear understanding of the disease or from unity of views in regard to it.

In the early part of our own century Trachoma began to especially attract the attention of the profession, as it was during that period that the armies of the Napolionic Wars in the East came so repeatedly in contact with each other and the civil population, the disease became widely disseminated and occurred in epidemics.

Statistics show that during the year 1818 there were more than five thousand on the invalid list in the English army who had been rendered blind as the consequence of Trachoma. In the Prussian army from 1813 to 1817 there were about thirty thousand men attacked by it and the percentage was equally great in the Russian army. In Belgium in 1840 one out of every five soldiers were victims of the disease.

Among civilians the disease finds favorable soil for dissemination where many people dwell together, hence, among the poorer classes, and particularly in large public asylums and work-houses do we find it prevalent. The disease is characterized by numerous oval massea in the palperbral conjunctiva, chronicity and by grave subsequent changes in the conjunctiva lids and frequently the globe.

It occurs at all ages, but is more frequently found in early adult life. By most authors it is divided into three classes, as mild, usual and violent; also three stages, as hypertrophic, coalescence and cicatrization.

In mild cases the granulations come on generally and may give the patient very little or no discomfort during the hypertrophic development, but more frequently after infection we find pronounced inflammation, increased lachrymation which is soon followed by a muco-purulent discharge; also the ocular conjunctiva becomes injected and we may find evidence of corneal involvement early in this stage. On everting the lids we find the conjunctiva thick and injected, also inflamed to such a degree that the granulations are covered up and not seen until the inflammation begins to subside. There is, however, most fortunately, a less frequent but very violent form of the disease with all of the exaggerated symptoms above mentioned, and with early and severe involvement of the cornea and adjacent lymphatic glands.

The hypertrophic stage may last only a few weeks or extend into months and gradually pass into the stage of coalescence or beginning cicatrization.

As the granules coalesce, cicatricial bands are formed throughout portions of the palpebral conjunctiva causing it to contract, also entropion and cupping



of the cartilage, and as a result of these contractions we have an increased tension on the cornea that causes abrasions, panus and not infrequently, corneal ulcers. If the patient is seen sufficiently early and given proper care, it is always necessary for it to pass through all of these stages as it may be arrested with the preservation of what normal tissue there is present at any part of the first or second stage of the disease.

In considering the cause, it is not necessarily confined to the poorer classes, but is most frequently met with among them as overcrowded buildings with poor ventilation, filth, improper and insufficient diet contribute largely to its production.

The geographical distribution of the disease has also attracted much attention and it has been found to be more prevalent among the Jews, Italians, Egyptians and other inhabitants of the East, while in other portions of the inhabited earth it is very rarely seen. This is especially true of the Scandinavian Peninsula, certain portions of California and in the higher altitude of our western country. Many researches have been made to discover the specific cause and a micro-organism has been isolated which bears a close relation to the disease; there has also been described a fungus and *aparacik* as the possible cause of the disease. Although it is believed to be a mycophetic disease, sufficient evidence has not been found to establish the identity of any known germ as the cause.

Pathologically, the granule is substantially a miniature lymph gland and is the essential element in Trachoma; they consist of a delicate indefinite connective tissue capsul containing a mass of lymphoid cells being transversed by very fine connective tissue trabeculae and are well supplied with small blood vessels. As the disease advances to

the second stage, the septa between the individual follicles disappear and the lymphoid mass becomes continuous, forming plaques of various sizes and the conjunctiva proper gives way to cicatricial tissue.

The epithelial covering of the granules vary in thickness and is irregular. The diagnosis in the early stage may be confounded with vernal catarrh, tuberculosis of the conjunctiva or Parinauds disease. The history of the case will usually be sufficient to distinguish it from vernal catarrh; if not the microscope will make it certain. In tubercular conjunctivitis the history of the case with the aid of the microscope makes the diagnosis certain, while in Parinauds disease the excessive involvement of the cervical and pre-auricular glands with the disease confined to one side is usually sufficient. The prognosis is only favorable when seen in the first stage or early in the second. When the cornea has become involved, further damage may be obviated, but the tissue that has been destroyed cannot be restored.

The treatment is prophylactic, medicinal and surgical. The disease should be treated as contagious, and in home care should be taken to require the patient to sleep alone, use individual towels and wash basins or any other article of toilet that might carry the infection.

In asylums, workhouses, barracks or schools, isolation should be enforced. The eyes should be frequently cleaned with boric acid solution or a mercuric chloride solution 1 to 15,000 to keep them free from discharge. During the muco-purulent stage a solution of nitrate of silver 5 to 10 grs. to the oz. or mercuric chloride daily until it subsides. After the discharge has diminished, the lids should be everted, and the copper sulphate pencil gently applied

over the conjunctival surface will prove very beneficial and is usually used as a routine treatment; should it prove too irritating, the sulphate of aluminum may be used instead. Should there be a tendency to Xerosis a 30% solution of boroglyceride may be found useful to relieve the dryness and is used by some during the whole course of treatment. Corneal complications always require atropine. An infusion of Jequerity, 3 to 5% may be used to create counter inflammation and cause absorption of the follicles.

The surgical treatment most used is expression either by the ring or roller forceps, and scarification of the epithelial surface facilitates the escape of the contents of the follicle. The lids being everted and thoroughly cocanized, if the patient is not under general anesthetic, are superficially scarified and the folds seized with the forceps and freed from the trachomatous tissue by a gentle stripping motion and cleaned with a mild antiseptic solution followed by cold boric acid compresses. The after treatment consists of an antiseptic cleaning and breaking down of any adhesion that may form.

Should there be any narrowing of the palpebrae fissure causing undue pressure on the cornea, canthoplasty should be resorted to, also an entropion is a common sequelae it should be operated on as indicated.

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#### The XVIth International Medical Congress.

Secretary.- General, Professor Emil Grosz, M. D.—Office, Budapest, VIII, Esterhazy-uteza 7. — In accordance with the resolution passed at Lisbon on the 26th of April, 1906, the XVIth International Medical Congress will be held at Budapest from the 29th of August till the 4th of September, 1909, inclusive.

#### COUNCIL SUBSTITUTE FOR HOUSE BILL NO. 84.

**An Act to Amend Chapter 34 of the Acts of the 37th Legislative Assembly, Entitled An Act to Regulate the Practice of Medicine in New Mexico, and to Establish a Board of Health and Medical Examiners.**

Be it enacted by the Legislative Assembly of the Territory of New Mexico:

Section 1. That Section 1 of Chapter 34 of the Session Laws of 1907 be, and the same is hereby amended by striking out all words thereof after and including the word "from" in line ten to and including the word "Association" in line 11 thereof and by striking out the words "from a similar list" in lines 11 and 12 thereof.

Section 2. That Section 3 of Chapter 34 of the Session Laws of 1907 be and the same is hereby amended by striking out the words, "who has been in the practice of his profession for two years next preceeding the time of making application for such license" in lines 4, 5 and 6 of said section, and the words "together with a list to be prepared by such board of colleges in good standing as defined by this act and such board may revise such list at any regular meetings," in lines 14, 15, 16, and 17 of said section.

Section 3. That section 4 of Chapter 34 of the Session Laws of 1907 be and the same is hereby amended by striking out the words "of colleges in good standing, as defined by this Act, who have not been in the active practice of their profession for two years next preceding the time of making application for license; also graduates" in lines 2, 3, 4, and 5 of said section, and insert after the word "college" in line 5, the words "in addition to those of," and strike out the word "than" in said line 5, and that said section be further amended by inserting in line 29 thereof, after the word "New Mexico," in said

line the words, "where such States and Territories reciprocate with New Mexico."

Section 4. The several Board of County Commissioners of the counties of this Territory shall annually, at the January term of said several Boards of County Commissioners, contract in writing with some reputable physician, who shall be the county health officer of such county, and such contract shall specify the compensation of such health officer, and such physician so appointed by said Board shall be a resident of the county, and he shall be subject to the orders of the Board of County Commissioners, and shall be their chief officer in the county for the purpose of carrying out any health regulations. He may with the consent of the County Commissioners, appoint as many assistant health officers in any county as the public health and safety may require. Such county health officer and his assistants, for the purpose of enforcing the provisions of this Act, shall be vested with all the powers vested by law in a constable of the county. The assistant health officer need not be a physician, but shall at all times act under the direction of the health officer.

Section 5. That the New Mexico Board of Health and Medical Examiners created by Chapter 34 of the Acts of the 37th Legislative Assembly, be vested with the powers and charged with the duties prescribed by Chapter 103 of the Acts of the 35th Legislative Assembly, and any Acts that may have been or may hereafter be passed, in amendment thereof;

Provided that the provisions of this Act shall not apply to incorporated cities or towns having a Board of Health or Health Officers.

Section 6. All laws and parts of laws in conflict with this Act are hereby repealed and this Act shall take effect and be in force from and after its passage.

#### THE STERILIZATION OF CRIMINALS AND OTHER DEFECTIVES BY VASECTOMY.

By William T. Belfield, M. D., Chicago.

Intelligent people everywhere are invited to consider the following statements:

(1) That the mentally defective classes—natural criminals, imbeciles, insane, epileptics—have multiplied in the last thirty years more than twice as fast as has the total population; (2) that only a few states have made the slightest effort to restrict procreation by these irresponsible parasites on society; (3) that males can be sterilized by a trifling operation, "vasectomy," without pain, danger or impairment of sexuality; unlike castration, vasectomy does not unsex a man; (4) that the Indiana legislature legalized this method two years ago, and that over 800 confirmed criminals have been thus sterilized in that state. Oregon has recently enacted a duplicate law, and similar bills have been introduced in at least two other state legislatures; (5) that the financial, moral and social health of every community would be obviously improved by the general adoption of this measure, which imposes no cruelty or hardship upon these defectives; (6) that true philanthropy demands this measure as a kindness to the as yet unbegotten offspring of the defective classes.

1. *Rapid Increase of the Irresponsible.* The published records of the Chicago Health Department show that homicides in that city steadily increased from 28 per million inhabitants in 1877, to 99 per million in 1907. The official records of the Illinois State Board of Charities, courteously furnished by Secretary W. C. Graves, show that the average number of inmates in the state asylums for the insane and feeble-minded had increased from 1981 in 1880 to 11,157 in 1907; in other words



from about 600 per million to about 2,000 per million inhabitants.

The best available records show that during the eight year period 1872-9 there were approximately 32 homicides per million of people throughout the United States; during the eight year period 1899-1906 the ratio had increased to 75 per million. In the ten year period 1886-95 there were in England 5 homicides per million inhabitants; in Germany 5 per million; in France 12, in Spain 45, in Italy 76 per million. Thus Italy alone rivals the United States in contempt for society's edict against murder. (It is a notable coincidence that while prior to 1880, less than 7 per cent. of our white immigrants came from southern and eastern Europe, since 1900 over 70 per cent. have come from these regions.)

Our efforts to restrict crime have been limited to inspiring fear of punishment; yet so medieval are our criminal codes, so impotent our so-called machinery of justice, that punishment is seldom so swift, sure or severe as to inspire wholesome fear of the law. The notorious inadequacy of our protection against crime, indicated by the occurrence of fifteen murders in the United States to one in England or Germany, was the subject of wise comment by President Roosevelt in his annual message to Congress in December, 1907.

2. *Efforts to Check the Procreation of the Unfit.* Under the existing order society carefully nurtures its irresponsible unfortunates in costly and ever multiplying infirmaries, to breed more of their own kind when at liberty; and the state pays the bills by taxing its wealthier citizens. Beyond forbidding the marriage of first cousins and those of still closer consanguinity, our communities have never placed the slightest check upon the production of defectives, except that five states (Minnesota,

Connecticut, Kansas, Michigan and Ohio) forbid the marriage of feeble-minded, epileptic and insane women under the age of 45 years. But since marriage is nowhere essential to procreation, least of all among the mentally defective, such laws—even if rigorously enforced—would not officiously restrain the breeding of irresponsibles. For example, of the hundreds of criminal, feeble-minded and otherwise defective descendants of the famous Jukes criminals, many were born out of wedlock.

3. *Vasectomy.* It is obvious that a measure which shall effectively prevent procreation by the mentally defective, must appeal not to their feeble minds but to their bodies; they must be made physically incapable of procreation. The idea is old; its easy and unobjectionable realization is new.

How shall this be accomplished? Three methods have been proposed—castration, colonization, vasectomy.

Sterilization of the male criminal by castration, though often discussed, will probably never secure legal sanction, because it destroys the subject's sexual power; it unsexes a man. For while different men worship different gods, all men worship the same goddess, Venus.

Colonization—the confinement of the mentally defective in colonies where access to the other sex should be impossible—has been often suggested as a bar to their propagation, though only by those who have never considered vasectomy. Thus at a recent discussion before the Physicians' Club of Chicago, an eminent speaker advocated colonization for preventing the breeding of human derelicts. When this gentleman's attention was subsequently called to the value of vasectomy to this end, he frankly endorsed it in these words: "This method of arresting the produc-

tion of criminals is, I am bound to believe, one of the coming blessings to humanity."

Vasectomy sterilizes a man without the slightest impairment of his sexual functions; it merely blocks the minute canal (the "vas") leading from the testis, through which the fertilizing elements of the male must pass to reach the organs which furnish the bulk of the seminal fluid. The absence of these elements from this fluid, though preventing pregnation, causes no impairment of sexual power or pleasure. This is abundantly proven by the robust sexual health of thousands of men who have been unwittingly sterilized through venereal disease, and who never suspect that their procreative functions are not perfectly normal until their marriages prove barren. That vasectomy itself is equally harmless to sexuality is shown by the experience of those upon whom it has been performed; among these, within my personal knowledge, are married men who chose this means, rather than criminal abortion, to prevent the transmission to offspring of their own hereditary taints, such as insanity and syphilis.

Vasectomy is an office operation; it is painlessly performed in a few minutes under cocaine anesthesia, through a skin cut half an inch long; it entails no wound infection, no confinement to bed; it is less serious than the extraction of a tooth.

The prevention of procreation by male defectives through vasectomy is not an iridescent dream. In March, 1907, the Indiana legislature passed a bill authorizing the sterilization of "confirmed criminals, idiots, imbeciles and rapists" in the state institutions of Indiana; over 800 convicts have been sterilized, some by authority of the state, but over 200 of them at their

own request. This voluntary submission to sterilization by hundreds of convicts, removes the only conceivable opposition to this method of protecting society—the ultra-sentimental.

In February, 1909, the Oregon legislature passed a duplicate of the Indiana bill, adding a definition of "confirmed criminals." This term "shall be deemed to apply to and include all persons serving a third term in any penitentiary or penal institution upon conviction of a felony."

While the first, chief and only needed argument for the sterilization of defectives is the protection of society, yet the sentimental may find additional ground for demanding it in the rescue of myriads of criminals, imbeciles and other defectives not yet begotten, from the misery and disaster that must otherwise attend them. Self-interest and altruism, the protection of society and true philanthropy, alike acclaim Indiana's epoch-making advance.

The average men, so soon as convinced that vasectomy is a trifling operation, and that it does not impair sexual pleasure, heartily approves this method of race suicide for criminals and other defectives, because of the obvious advantage to the community; the sentimentalist, who places unselfish love for the defective above the safety of his own family from burglar and rapist, should be reminded that the greatest kindness that can be shown to the as yet unbegotten offspring of the feeble-minded of all kinds, is to help them to remain unbegotten.

This simple and unobjectionable method of checking the breeding of criminals and other judicially pronounced unfit for citizenship, seems worthy of national attention.

(In women the corresponding

sterilizing operation, though practicable, is not entirely devoid of danger, as it is in men.)

#### Editorial Comment.

Chicago Evening Post, March 27, 1909.—“Propagation or the Unfit. Two rather wild sons of an early Dutch settler in New York State married two sisters. Of their 1,200 descendants the careers of 709 have been traced. Of those traced 280 were public paupers, 140 were criminals and a very large number were depraved, diseased and insane. In seventy-five years that family cost the people of the United States \$1,308,000.

They are known as the “Jukes.” But the Jukes family” is by no mean an exception. The down-and-outs are notoriously prolific, partly from their very irresponsibility. Heredity plays a portentous part in the production of criminals and defectives; this element of heredity must, sooner or later, be eliminated. Even on the most sentimental basis the confirmed criminals and other serious defectives have no right to hand on their taint to innocent children.

In March, 1907, the State of Indiana passed a law authorizing the painless sterilization of “confirmed criminals, idiots and imbeciles” in the state institutions by vasectomy. A board of three responsible physicians pass upon the cases. Over 800 convicts have undergone this simple, painless operation—some 200 of them at their own request.

It is no exaggeration to say that vasectomy is one of the most important reforms before the people of Illinois today. Rarely has a big thing come with so little fanfare of trumpets.”

Chicago Tribune, April 5, 1909.—“Society’s Self Protection. Dr. Frank Billings, in his plea for an adequate appropriation for the state charitable institutions, called the attention of the

appropriations committee of the house to an alarming fact.

This fact is the increase of defectives cared for by the state. It is 300 per cent in thirty years!

No wonder the startled legislators cried, “Can’t this be stopped?” It is only because the people do not know the fact that the demand for protective measures does not sweep the state.

This evil can be checked and by reasonable and unobjectionable means. Laws against the marriage of the feeble minded, epileptic, and insane exist in many states, but they are ineffectual. The prevention of the breeding of defectives is urgently necessary, and in Indiana a system more practical than colonization and not objectionable on the usual grounds has been devised and is in satisfactory operation.

Senator Womack has introduced a sterilization bill at the present session which has just been reported favorably by the judiciary committee. It has the approval of the Chicago Society of Social Hygiene, the Chicago Medical Society has just indorsed it, and the profession generally undoubtedly favors it. The bill should become law.

The sterilization of defectives and of habitual criminals is a necessary measure of social economy.”

Journal American Medical Association, April 3, 1909.—“The sterilization of criminals and defectives by vasectomy is becoming a live question in many directions. This method of combating the transmission of criminality and other mental defects—a peril that has assumed such proportions as to arouse the attention of most civilized countries—has now been in use in Indiana for two years, and recently has been legalized in Oregon. The matter has been taken up by the Chicago Society of Social Hygiene, with a view to public education thereon and the intro-



duction of some similar measure in the state of Illinois. There is a bill (No. 249) now in committee of the Illinois senate which appears to cover the ground. The state's concern in the matter is limited to the prevention of procreation of hereditarily defective offspring, and this appears to be perfectly effected by the safe, harmless, non-mutilating operation of vasectomy."

The sterilization of convicts and other judicially declared unfit for citizenship, has been officially recommended to general attention by the Chicago Medical Society (2,100 members), the Chicago Physician's Club, the Southern District Medical Society and the Chicago Society of Social Hygiene.

The Indiana sterilization law, enacted in Oregon also is appended:

"Preamble — Whereas, Heredity plays a most important part in the transmission of crime, idiocy and imbecility:

Therefore, Be it enacted by the General Assembly of the State of Indiana that on and after the passage of this act it shall be compulsory for each and every institution in the state, entrusted with the care of confirmed criminals, idiots, rapists and imbeciles, to appoint upon its staff, in addition to the regular institutional physician, two skilled surgeons of recognized ability, whose duty it shall be, in conjunction with the chief physician of the institution, to examine the mental and physical condition of such inmates as are recommended by the institutional physician and board of managers. If, in the judgment of this committee of experts and the board of managers, procreation is inadvisable and there is no probability of improvement of the mental condition of the inmate, it shall be lawful for the surgeons to perform such operation for the prevention of procreation as shall be de-

cided safest and most effective. But this operation shall not be performed except in cases that have been pronounced unimprovable."

Toward the close of the recent meeting of the A. M. A., Atlantic City, June 10th, the following officers were elected:

President—Dr. William H. Welch, Baltimore, Md.

First Vice-President—Dr. Robert Wilson, Charleston, S. C.

Second Vice-President—Dr. Chas. J. Kipp, Newark, N. J.

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Trustees—Dr. C. E. Cantrell, Texas; Dr. M. L. Harris, Chicago; Dr. C. A. Daugherty, South Bend; Dr. William T. Councilman, Boston.

Dr. Chas. A. L. Reed, Cincinnati, succeeds himself as chairman of the Committee on Medical Legislation.

Dr. Arthur Dean Bevan, Chicago, succeeds himself as chairman of the Council on Medical Education.

#### A MODERN IMPROVEMENT.

Three doctors were operating on a man for appendicitis. After the operation was completed one of the doctors missed a small sponge. The patient was reopened, the sponge found within, and the man sewed up again. Immediately the second doctor missed a needle. Again the patient was opened and closed. Then the third doctor missed a pair of scissors. "Gentlemen," said the victim as they were about to open him up again, "for heaven's sake, if you're going to keep this up, put buttons on me."—R. Bibelow Lockwood.

**REPORT OF A CASE OF TRAUMATIC  
EPILEPSY OF 24 YEARS STANDING  
RELIEVED BY OPERATION.**

By Dr. M. K. Wylder, Albuquerque.

It is not my purpose in this paper to go into the history of surgical interference for epilepsy which, while very interesting as it has been practiced for centuries, is doubtless familiar to you all.

Nor do I intend to go to seed on the technic of the various operative procedures with which our text-books abound.

We will, therefore, dispense with preliminaries and begin at once with the case which originated here at home, and is of far more interest to us as members of the New Mexico Medical Society than the fine spun theories which may be had at your leisure.

Miss M. first came under my observation April 10, 1907, for a radiographic examination. Her history, briefly stated, was as follows: Thirty-two years of age, had had the usual diseases of childhood, and aside from the conditions for which she presents herself her health had always been good. Family history negative with regard to epilepsy or nervous dyscrasia.

The present trouble dates from her eighth year of age when she began to have epileptic seizures and continued to have them at irregular intervals until she was about twelve years of age, when a period of four years elapsed with no recurrent attacks, after which they were renewed with vigor and continued, gradually growing worse and worse up to the time of taking this history.

Her general appearance is indicative of her trouble, a tall, slim, anaemic, brunette with drawn features and expressionless eye bordering on the meaningless stare of an imbecile.

On examination I found a depression  $\frac{1}{2}$  inch in length anterior posteriorly and  $\frac{3}{8}$  inch in width located on the right side of the skull midway between the parietal eminence and the parietal foramen. On inquiry, I found that when she was eleven years of age that she had sustained a fall from a swing, resulting in a fractured skull, which was followed by a suppurative discharge for a period of four years, perhaps, from an osteomyelitis and during this time she was entirely free from epilepsy, but with resolution and diminution of the discharges the attacks became more and more pronounced until her condition became alarming, and an operation was considered for the relief of the depression if not for the epilepsy. However they were deterred by the ugly fact that the epilepsy first developed when she was eight years of age. However, upon minute inquiry it was remembered that when she was seven years of age she had fallen from a cherry tree and had bruised her head. Thus it will be seen that at eight, or one year later, the epilepsy first appeared. That at eleven another fall from a swing evidently fractured the skull in the identical location that was before fractured, this last by its osteomyelitis and consequent discharge relieved the pressure and the patient was free from these attacks, as long as this pressure was so relieved, but they returned upon the diminution of the discharge and the increase of pressure.

My diagnosis, therefore, was a fracture of the skull at seven years of age, another at eleven, probably in the same place and that surgical interference, while on account of the long period of time since the accident did not hold out a great deal of hope, was at least warranted as a last resort. My colleague, Dr. Cornish, was called and after going

over the case carefully he coincided with my views and with his able assistance the operation was undertaken.

The inner table of bone was found to be depressed and adherent to the membranes. This portion of bone was removed and these adhesions broken up. The patient made an uneventful recovery, and notwithstanding the fact that she had a seige of typhoid fever, six months after the operation I am pleased to report that today, seventeen months since the operation, she is in good health, free from epilepsy and her mental condition is much improved.

#### MAMMALIAN BLOOD IN BLOOD-SUCKING INSECTS.

Many infectious diseases, including malaria, yellow fever, Texas fever and the African sleeping sickness, are caused by protozoa carried from one human being or animal to another by such blood-sucking insects as ticks, Anopheles mosquitoes, and tsetse flies.

As the extermination of the crocodiles, the rhinoceros and other large animals has been proposed as a means to the extermination of the insect carriers of disease, Uhlenhuth, Weidanz, and Angleloff have been conducting a series of experiments in order to determine from which animal species the insects draw blood. The well-known biological method by which an exceedingly minute quantity of blood can be detected and its species determined was employed. It was found that the red corpuscles of blood sucked by leeches remained intact in their bodies for eight weeks. In bedbugs the presence of human blood could be detected two weeks after it had been drawn. Similar results were obtained with human and animal blood in lice, fleas and ticks. A number of mosquitoes of the species

Anopheles, which has been supposed to feed chiefly on human blood, yielded only blood derived from cattle and swine. Uhlenhuth is planning a new series of experiments for the purpose of determining whether the rat flea, which has been accused of disseminating plague, does or does not suck human blood.—Scientific American.

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